Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.4

Submitted by:

District of Columbia Medical Assistance Administration

Submission Date:	

CMS Receipt Date *(CMS Use)*	

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment):

Brief Description:
This is a request for a renewal of the waiver serving participants with mental retardation and developmental disabilities in the District of Columbia.

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

1. Request Information

A. The **State** of The District of Columbia requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Waiver Title (*optional*): # 0307.90

C. Type of Request *(select only one)*:

O	**New Waiver (3 Years)**	CMS-Assigned Waiver Number (*CMS Use*):	
O	**New Waiver (3 Years) to Replace Waiver #**		
	CMS-Assigned Waiver Number (*CMS Use*):		
	Attachment #1 contains the transition plan to the new waiver.		
X	**Renewal (5 Years) of Waiver #**		
O	**Amendment to Waiver #**		

D. Type of Waiver *(select only one)*:

O	**Model Waiver**. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
X	**Regular Waiver**, as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date: November 1, 2007

E.2 Approved Effective Date *(CMS Use)*:

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan *(check each that applies)*:

☐	Hospital *(select applicable level of care)*	
	O	Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
	O	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
☐	Nursing Facility *(select applicable level of care)*	
	O	As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
	O	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
X	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:	

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities *(check the applicable authority or authorities)*:

☐	Services furnished under the provisions of §1915(a) of the Act and described in Appendix I			
☐	Waiver(s) authorized under §1915(b) of the Act. *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*			
	Specify the §1915(b) authorities under which this program operates (*check each that applies*):			
	☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
	☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)
☐	A program authorized under §1115 of the Act. *Specify the program:*			
X	Not applicable			

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The purpose of the DDS Waiver, a 1915 C waiver, is to assist service participants in leading healthy, independent and productive lives to the fullest extent possible; promote the full exercise of their rights as citizens of the District of Columbia; and promote the integrity and well-being of their families. Services are provided with the goal of promoting independence through strengthening the individual's capacity for self-care and self-sufficiency. This waiver creates the fiscal platform for a service system centered on the needs and preferences of the participants and supports the integration of the participants within their communities. The DDS serves to provide an on-going opportunity for individuals with developmental disabilities to transition from ICFs-MR and provide residential and other comprehensive supports for people with complex needs.

The objectives of the DDS Waiver are to:

- Promote independence for participants through the provision of services meeting the highest standards of quality and national best practices, while ensuring health and safety through a comprehensive system of participant safeguards;
- Offer an alternative to institutionalization and costly comprehensive services through the provision of an array of services and supports that promote community inclusion and independence by enhancing and not replacing existing informal networks;
- Support participants and their families to exercise their rights and share responsibility for their programs regardless of the method of service delivery; and
- Offer access to services on a short tem basis that would protect the health and safety of the participant if the family or other care giver were unable to continue to provide care and supervision.

The Medical Assistance Administration (MAA) is the Single State Medicaid Agency which maintains administrative and supervisory oversight of the DDS Waiver. MAA designates the authority for implementing the program(s) and for programmatic oversight of the waiver to the Department of Disability Services, through an interagency agreement.

Services are accessed through a single point of entry within DDS. Initially, applicants are assessed by the DDS Clinical Services Team, who determines eligibility. All applicants enter the DDS gateway in a "pending" status. When DDS makes the determination to deliver the service to the applicant, the participant chooses between ICF-MR and HCBS services. Those of who have chosen the ICF option are assessed by Delmarva, a private entity whose services are contracted by MAA. Those participants who have chosen the HCBS option are processed by DDS, which includes a level of care determination. All waiver participants choose their Direct Service Provider Agencies through the Freedom of Choice process. All services must be prior authorized and delivered in accordance with an approved Plan of Care. The Plan of Care is approved by DDS. Prior authorization is completed by DDS and they also maintain the service data for this waiver.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. **Appendix A** specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. **Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. **Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. **Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one)*:

O	The waiver provides for participant direction of services. *Appendix E is required.*
X	Not applicable. The waiver does not provide for participant direction of services. *Appendix E is not completed.*

F. Participant Rights. **Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. **Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Management Strategy. **Appendix H** contains the Quality Management Strategy for this waiver.

I. Financial Accountability. **Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. **Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

X	Yes
O	No
O	Not applicable

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

O	**Yes** *(complete remainder of item)*
X	**No**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐	**Geographic Limitation**. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area*:
☐	**Limited Implementation of Participant-Direction**. A waiver of statewideness is requested in order to make ***participant direction of services*** as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. *Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area*:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected amount, frequency and duration and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial

participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Management. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

Public input was obtained throughout the development of the waiver by a variety of methods. DDS established a District-wide Stakeholder Group solely for the purpose of giving input into the waiver. The Group included representation by people with developmental disabilities, providers, family members and local advocacy organizations such as the federally-funded Protection and Advocacy organization and the Quality Trust [note: the Quality Trust for Individuals with Disabilities, Inc. (Quality Trust) is an independent, nonprofit advocacy organization created to advance the individual and collective interests of people with developmental disabilities and mental retardation in the District of Columbia. The activities of Quality Trust include monitoring the adequacy of services

available including ensuring health, safety and welfare issues are addressed, providing lay advocacy services and ensuring access to legal representation. The Quality Trust was established by a court order in the Evans Settlement Agreement in 2001.] and was held in an open-meeting format. The Group was tasked by DDS with the responsibility of relaying information about the waiver to their constituents and bringing feedback to DDS from these constituents, thus promoting two-way communication. The Stakeholder Group was invaluable throughout the waiver development process, most especially in the areas of service definitions, quality management (including participant protections), Plan of Care, rate-setting and rule issues.

DDS has traditionally hosted a monthly Waiver Committee, a small work composed of representation similar to the Stakeholder Group. This Committee reviewed each iteration of the draft waiver throughout its development and focused on all aspects of the waiver.

Day-to-day development of the waiver included a representative of the aforementioned Quality Trust, who worked closely with officials from the Medical Assistance Administration and the Department on Disability Services.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Robert
Last Name	Cosby
Title:	Chief, Office on Disabilities and Aging
Agency:	District of Columbia Department of Health
Address 1:	825 North Capitol Street, NE
Address 2:	Suite 5135
City	Washington
State	DC
Zip Code	20002
Telephone:	(202) 442-5972
E-mail	Robert.cosby@dc.gov
Fax Number	(202) 442-4799

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2	
City	
State	
Zip Code	
Telephone:	
E-mail	
Fax Number	

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: _____ **Date:** _____

State Medicaid Director or Designee

First Name:	Robert
Last Name	Maruca
Title:	Senior Deputy Director
Agency:	Medical Assistance Administration, D.C. Department of Health
Address 1:	825 North Capitol Street, NE
Address 2:	Suite 5135
City	Washington
State	DC
Zip Code	20002
Telephone:	(202) 442-5988
E-mail	robert.maruca@dc.gov
Fax Number	(202) 442-4790

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

We will need to determine how transition to the new services will occur

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver *(select one)*:

O	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one; do not complete Item A-2*):
	O The Medical Assistance Unit *(name of unit)*:
	O Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (name of division/unit)
X	The waiver is operated by **Department of Disability Services**, a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *Complete item A-2.*

2. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The Medical Assistance Administration (MAA) is the single state Medicaid agency of the District of Columbia. Responsibilities accorded to MAA as related to policy development and the administration of the medical assistance program can be found at D.C. Official Code §1-307.02 et seq. as authorized by Titles XIX and XXI of the Social Security Act. The Department of Disability Services (DDS) is the operating agency for all services provided to persons with developmental disabilities and mental retardation. The two agencies have a Memorandum of Understanding (MOU) to assure cooperation and collaboration between MAA and DDS in performance of their respective duties in the provision of Home and Community Based Waiver services. The purpose of this MOU is to satisfy the state and federal requirements regarding the role of MAA as the single state Medicaid agency, to outline financial obligations and arrangements between these agencies and to define the roles of each agency.

The MOU defines the cooperative agreement between the agencies in the following areas of responsibility:
I. Provider certifications;
II. On-line authorizations for DDS waiver services;
III. Electronic billing for DDS providers;
IV. Communication and data exchange; and
V. Policy development.

The responsibilities for each agency are detailed as follows:

I. PROVIDER CERTIFICATION

DOH/MAA:

1. Provides technical assistance and training to DDS's staff on the provider certification and enrollment process.

2. Provides specific protocols that include: criteria for initial screening, formal assessment and certifications, i.e., copies of all tools used to assess provider qualifications.

3. Provides tracking forms to document certification and enrollment process. The tracking forms include dates, assignments, reviews of materials submitted, verification and other information.

4. Issues Medicaid Transmittals to new and existing home and community based waiver providers that outline certification procedures for new certifications and for redeterminations.

5. Includes the Medicaid Waiver Provider Manual information regarding DDS's role and responsibilities in the certification process.

6. Upon receipt of completed provider certification packets from DDS, MAA enrolls and issues a Medicaid provider number.

7. Upon receipt of provider packets from DDS that have been deemed unacceptable, MAA returns the documentation to the Provider with a denial letter to the provider that specifies which requirements have not been met.

DDS:
1. Maintains a single point of entry for provider certification.

2. Maintains full responsibility for determining and predetermining that home and community based waiver providers meet required licensing and/or certification standards, where required.

3. Verifies provider qualifications in accordance with established MAA policies, procedures and regulations.

4. Recommends Medicaid enrollment for only those providers or entities that can demonstrate they are qualified in accordance with established Medicaid policies, procedures and regulations.

5. Develops and maintains a centralized database that includes documentation, correspondence and recommendations related to receipt of provider applications and disposition.

6. Processes all requests for certification within 30 days of receipt of the request for certification.

7. Submits all provider applications, correspondence, and recommendations for enrollment in the waiver program to MAA within 45 days of receipt of the provider application as required under 29 DCMR Chapter 19 (the Home and Community Based Waiver Services for Persons with Mental Retardation and Developmental Disabilities General Provisions).

8. Issues a letter to the provider and MAA stating that the provider is certified and/or recertified as a Medicaid Waiver Provider.

9. If the documentation is incomplete, DDS returns the documentation to the provider and MAA with a letter identifying the missing information. If the provider's documentation does not meet the requirements, DDS issues a letter denying certification to the provider that specifies requirements that

have not been met.

II. ON-LINE AUTHORIZATION FOR DDS WAIVER SERVICES

MAA:

1. Provides training and technical assistance to DDS's staff on the submission of on-line authorizations for DDS waiver services via the Medicaid Management Information System (MMIS)

2. Provides detailed instructions (user manual) on the on-line authorization process.

3. Issues provider authorization notice and authorization number with-in 24 hours of receipt of approval from DDS.

4. Issues denial and cancellation of service notices with-in 24 hours of receipt from DDS.

5. Issues Medicaid Transmittal notifying new and existing home and community based waiver providers outlining on-line authorization process.

6. Interfaces transaction information with DDS's MCIS.

7. Provides written communication, workshops, and personal visits to provider sites when requested on the revised authorization and billing process.

8. Provides web and Internet capabilities to provide information on the authorization and claims adjudication.

DDS:

1. Maintains a single point of contact for billing and provider relations.

2. Maintains authorization worksheets in waiver participants' files.

3. Issues authorizations to Medicaid beneficiaries and their case managers regarding the disposition of waiver service requests, provider selection and start and end dates of service.

4. Participates in workshops and trainings for providers on the revised authorization and billing process.

5. Submits all change requests with-in 24 hours of receipt from the case manager to MAA's fiscal intermediary for issuance of authorization notices and an authorization approval number.

III. ELECTRONIC BILLING FOR MRDDA HOME AND COMMUNITY-BASED PROVIDERS

MAA:

1. Allows providers to submit electronic and/or hard copy claims.

2. Provide written communication, workshops and on-site provider training on electronic claims submissions for the home and community-based waiver.

3. Designates staff to provide ongoing technical assistance with scheduled hours and a 24-hour turnaround during unscheduled hours.

4. Ensures that electronic billing complies with the HIPPA format and content requirements.

5. Allows providers to retrieve their remittances, check recipient eligibility, and get claims, attachments, check amounts and prior authorization status on-line.

DDS:

1. Identifies provider readiness and capability to submit claims electronically.

2. Participates in in-house workshops and training on electronic claim submissions and provide staff for joint technical support during scheduled times or sessions.

3. Ensures that funds are available, as determined by the agency Administrator, to adequately support electronic billing supports.

IV. COMMUNICATION AND DATA EXCHANGE

DDS and MAA:

1. Jointly develop all policy and instructional communications to providers related to covered services.
2. Convene the DDS Waiver Advisory Group to reduce fragmentation and promote a strong and effective service delivery system.

MAA:

1. Provides monthly reports and/or access to standardized reporting capabilities to detail prior authorizations by consumer and/or by provider and regular reports of service reimbursements for prior authorized services. If DDS cannot produce its own reports MAA will provide summary reports on weekly and monthly basis. All reports will be provided in an electronic flat file format appropriate to being uploaded into DDS's Consumer Information System.

2. Provides on a quarterly basis reconciliation reports by participant and provider that reconcile prior authorizations against reimbursements. These reports will be provided in hard copy and as Adobe Acrobat files and in an electronic flat file format appropriate to being uploaded into DDS's Consumer Information System.

DDS:

1. Actively participates and is involved closely and regularly with MAA in the development of expenditure forecasting models, budget proposals, and submission of covered services.
2. Analyzes data from the expenditure reports for the covered waiver services and the impact on budget neutrality.

V. POLICY DEVELOPMENT

MAA and DDS coordinate all mutual policy issues related to the operation of the Medicaid program, including changes in policy and procedure. All proposed rules are reviewed by the DDS Waiver Advisory Group, which MAA and DDS jointly.

MAA audits DDS's performance as the operating agency by the following procedures: 10 % of participants served by the waiver from at least two providers are sampled. Claims filed on behalf of these participants are reviewed and if inconsistencies in claiming procedures are identified, MAA conducts site visits. The DDS Waiver Office submits all participant Plans of Care to MAA, who conducts a review of a sample of these Plans to determine the appropriateness of the Plans and if services are delivered as requested; MAA conducts routine site visits to augment the documentation review. The DDS Program Integrity Unit submits all Continuous Quality Improvement (CQI) reports to MAA quarterly and MAA samples 10% of these reports to review utilization. MAA conducts routine site visits to verify documentation received by DDS.

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the waiver operating agency (if applicable) (*select one)*:

X	**Yes.** Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6*
	The DC Department of Health Office of Program Operations contracts with a fiscal management service that monitors waiver expenditures against approved levels and conducts training and technical assistance concerning waiver requirements, specifically claiming procedures.
O	**No**. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

4. **Role of Local/Regional Non-State Entities**. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity *(check each that applies)*:

☐	**Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:*
☐	**Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a **contract** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these entities and complete items A-5 and A-6*:

X	**Not applicable** – Local/regional non-state agencies do not perform waiver operational and administrative functions.

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The DC Department of Health Office of Program Operations is responsible for monitoring the performance of the fiscal management service.

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Information about assessment methods and frequency of ACS; this information is not referenced in EPD waiver. We need MAA to provide us with this information

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	☐	X	☐	☐
Assist individuals in waiver enrollment	X	X	☐	☐
Manage waiver enrollment against approved limits	X	X	☐	☐
Monitor waiver expenditures against approved levels	X	X	X	☐
Conduct level of care evaluation activities	☐	X	☐	☐
Review participant service plans to ensure that waiver requirements are met	X	X	☐	☐
Perform prior authorization of waiver services	X	X	☐	☐
Conduct utilization management functions	☐	X	☐	☐
Recruit providers	☐	X	☐	☐
Execute the Medicaid provider agreement	X	X	☐	☐
Determine waiver payment amounts or rates	X	☐	☐	☐
Conduct training and technical assistance concerning waiver requirements	X	X	X	☐

Appendix B: Participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Select one Waiver Target Group		Target Group/Subgroup	Minimum Age	Maximum Age	
				Maximum Age Limit: Through age –	No Maximum Age Limit
O	**Aged or Disabled, or Both** *(select one)*				
	O	**Aged or Disabled or Both – General** *(check each that applies)*			
	☐	Aged (age 65 and older)			☐
	☐	Disabled (Physical) (under age 65)			
	☐	Disabled (Other) (under age 65)			
	O	**Specific Recognized Subgroups** *(check each that applies)*			
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
X	**Mental Retardation or Developmental Disability, or Both** *(check each that applies)*				
	☐	Autism			☐
	X	Developmental Disability	14		X
	X	Mental Retardation	14		X
O	**Mental Illness** *(check each that applies)*				
	☐	Mental Illness (age 18 and older)			☐
	☐	Serious Emotional Disturbance (under age 18)			

b. Additional Criteria. The State further specifies its target group(s) as follows:

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one)*:

X	Not applicable – There is no maximum age limit
C	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit (*specify*):

Appendix B-2: Individual Cost Limit

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*:

X	**No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or Item B-2-c.*
O	**Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.* The limit specified by the State is *(select one)*:
	O ____ %, a level higher than 100% of the institutional average
	O Other *(specify)*:
O	**Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
O	**Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*
	The cost limit specified by the State is *(select one)*:
	O The following dollar amount: $ ____
	The dollar amount *(select one)*:
	O Is adjusted each year that the waiver is in effect by applying the following formula:
	O May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.
	O The following percentage that is less than 100% of the institutional average: ____ %
	O Other – *Specify:*

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

☐	The participant is referred to another waiver that can accommodate the individual's needs.
☐	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
☐	Other safeguard(s) *(specify)*:

Appendix B-3: Number of Individuals Served

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	1455
Year 2	1555
Year 3	1655
Year 4 (renewal only)	1755
Year 5 (renewal only)	1855

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

X	The State does not limit the number of participants that it serves at any point in time during a waiver year.
O	The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

X	**Not applicable**. The state does not reserve capacity.
O	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:
	The capacity that the State reserves in each waiver year is specified in the following table:

Table B-3-c

Waiver Year	Purpose:	Purpose:
	Capacity Reserved	Capacity Reserved
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one):*

●	The waiver is not subject to a phase-in or a phase-out schedule.
O	The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an ***intra-year*** limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity. *Select one:*

●	Waiver capacity is allocated/managed on a statewide basis.
O	Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Waiver criteria are: 1) a District of Columbia resident currently receiving services from DDS; 2) a Medicaid recipient with income up to 300 % of SSI; and 3) Meets functional criteria of needing

assistance with at least two Activities of Daily Living and three Instrumental Activities of Daily Living. DDS manages a wait list using a first come, first served basis.

Attachment #1 to Appendix B-3

Waiver Phase-In/Phase Out Schedule

a. The waiver is being *(select one)*:

O	Phased-in
O	Phased-out

b. **Waiver Years Subject to Phase-In/Phase-Out Schedule** *(check each that applies)*:

Year One	Year Two	Year Three	Year Four	Your Five
☐	☐	☐	☐	☐

c. **Phase-In/Phase-Out Time Period**. *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

d. **Phase-In or Phase-Out Schedule**. *Complete the following table:*

Phase-In or Phase-Out Schedule			
	Waiver Year:		
Month	Base Number of Participants	Change in Number of Participants	Participant Limit

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

a. State Classification. The State is a *(select one)*:

X	§1634 State
O	SSI Criteria State
O	209(b) State

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)				
X	Low income families with children as provided in §1931 of the Act			
X	SSI recipients			
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121			
X	Optional State supplement recipients			
X	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*			
	X	100% of the Federal poverty level (FPL)		
	O	%	of FPL, which is lower than 100% of FPL	
☐	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)			
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)			
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)			
☐	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)			
X	Medically needy			
☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:			
Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*				
O	**No**. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.			
X	**Yes**. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5.*			
	O	All individuals in the special home and community-based waiver group under 42 CFR §435.217		

	X	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:			
	X	A special income level equal to (select one):			
		X	300% of the SSI Federal Benefit Rate (FBR)		
		O	%	of FBR, which is lower than 300% (42 CFR §435.236)	
		O	$	which is lower than 300%	
	☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)			
	☐	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)			
	☐	Medically needy without spend down in 209(b) States (42 CFR §435.330)			
	X	Aged and disabled individuals who have income at: *(select one)*			
		X	100% of FPL		
		O	%	of FPL, which is lower than 100%	
	☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:			

Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one)*:

X	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (*select one*):	
	X	Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.*
	O	Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). Do not complete Item B-5-d.*
O	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. *Complete Item B-5-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*	

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

b-1. Regular Post-Eligibility Treatment of Income: SSI State and §1634 State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
O	The following standard included under the State plan *(select one)*			
	O	SSI standard		
	O	Optional State supplement standard		
	O	Medically needy income standard		
	O	The special income level for institutionalized persons *(select one):*		
		C	300% of the SSI Federal Benefit Rate (FBR)	
		C	%	of the FBR, which is less than 300%
		C	$	which is less than 300%.
	O	%	of the Federal poverty level	
	O	Other (specify):		

O	The following dollar amount:	$	If this amount changes, this item will be revised.
O	The following formula is used to determine the needs allowance:		

ii. Allowance for the spouse only (*select one*):

O	SSI standard		
O	Optional State supplement standard		
O	Medically needy income standard		
O	The following dollar amount:	$	If this amount changes, this item will be revised.
O	The amount is determined using the following formula:		
O	Not applicable *(see instructions)*		

iii. Allowance for the family *(select one)*:

O	AFDC need standard		
O	Medically needy income standard		
O	The following dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
O	The amount is determined using the following formula:		
O	Other (specify):		
O	Not applicable *(see instructions)*		

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

O	Not applicable *(see instructions)*
O	The State does not establish reasonable limits.
O	The State establishes the following reasonable limits *(specify)*:

c-1. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- O The following standard included under the State plan *(select one)*
  - O The following standard under 42 CFR §435.121:
  - O Optional State supplement standard
  - O Medically needy income standard
  - O The special income level for institutionalized persons *(select one)*
    - O 300% of the SSI Federal Benefit Rate (FBR)
    - O % of the FBR, which is less than 300%
    - O $ which is less than 300% of the FBR
  - O % of the Federal poverty level
  - O Other (specify):
- O The following dollar amount: $ If this amount changes, this item will be revised.
- O The following formula is used to determine the needs allowance:

ii. Allowance for the spouse only (*select one*):

- O The following standard under 42 CFR §435.121
- O Optional State supplement standard
- O Medically needy income standard
- O The following dollar amount: $ If this amount changes, this item will be revised.
- O The amount is determined using the following formula:
- O Not applicable *(see instructions)*

iii. Allowance for the family *(select one)*

- O AFDC need standard
- O Medically needy income standard

O	The following dollar amount: $ [ ] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
O	The amount is determined using the following formula:
O	Other (specify):
O	Not applicable *(see instructions)*

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

O	Not applicable *(see instructions)*
O	The State does not establish reasonable limits.
O	The State establishes the following reasonable limits *(specify)*:

NOTE: Items B-5-c-2 and B-5-d-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

b-2. Regular Post-Eligibility Treatment of Income: SSI State and §1634 state. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):				
X	The following standard included under the State plan *(select one)*			
	X	SSI standard		
	O	Optional State supplement standard		
	O	Medically needy income standard		
	O	The special income level for institutionalized persons *(select one):*		
		C	300% of the SSI Federal Benefit Rate (FBR)	
		C	%	of the FBR, which is less than 300%
		C	$	which is less than 300%.
	O	%		of the Federal poverty level
	O	Other (specify):		

O	The following dollar amount:	$	If this amount changes, this item will be revised.
O	The following formula is used to determine the needs allowance:		

ii. Allowance for the spouse only (*select one*):

O	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:		
	Specify the amount of the allowance:		
	O SSI standard		
	O Optional State supplement standard		
	O Medically needy income standard		
	O The following dollar amount:	$	If this amount changes, this item will be revised.
	O The amount is determined using the following formula:		
X	Not applicable *(see instructions)*		

iii. Allowance for the family *(select one)*:

O	AFDC need standard		
O	Medically needy income standard		
O	The following dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
O	The amount is determined using the following formula:		
O	Other *(specify)*:		
X	Not applicable *(see instructions)*		

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

X	Not applicable *(see instructions)*
O	The State does not establish reasonable limits.

O	The State establishes the following reasonable limits *(specify)*:

c-2. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
O	The following standard included under the State plan *(select one)*			
O	The following standard under 42 CFR §435.121:			
O	Optional State supplement standard			
O	Medically needy income standard			
O	The special income level for institutionalized persons *(select one)*			
O	300% of the SSI Federal Benefit Rate (FBR)			
O	%	of the FBR, which is less than 300%		
O	$	which is less than 300% of the FBR		
O	%	of the Federal poverty level		
O	Other (specify):			
O	The following dollar amount:	$	If this amount changes, this item will be revised.	
O	The following formula is used to determine the needs allowance:			
ii. <u>Allowance for the spouse only</u> (*select one*):				
O	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:			
	Specify the amount of the allowance:			
O	The following standard under 42 CFR §435.121:			
O	Optional State supplement standard			
O	Medically needy income standard			
O	The following dollar amount:	$	If this amount changes, this item will be revised.	

	O	The amount is determined using the following formula:
O		Not applicable *(see instructions)*

iii. Allowance for the family *(select one)*

O	AFDC need standard
O	Medically needy income standard
O	The following dollar amount: $ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
O	The amount is determined using the following formula:
O	Other (specify):
O	Not applicable *(see instructions)*

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

O	Not applicable *(see instructions)*
O	The State does not establish reasonable limits.
O	The State establishes the following reasonable limits *(specify)*:

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care.

i. <u>Allowance for the personal needs of the waiver participant</u> *(select one)*:			
O	SSI Standard		
O	Optional State Supplement standard		
O	Medically Needy Income Standard		
O	The special income level for institutionalized persons		
O	%	of the Federal Poverty Level	
O	The following dollar amount:	$	If this amount changes, this item will be revised
O	The following formula is used to determine the needs allowance:		
O	Other (*specify*):		
ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. *Select one:*			
O	Allowance is the same		
O	Allowance is different. Explanation of difference:		
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:			
a. Health insurance premiums, deductibles and co-insurance charges. b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*			
O	Not applicable *(see instructions)*		
O	The State does not establish reasonable limits.		
O	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.		

Appendix B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for waiver services:

i.	**Minimum number of services.** The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is *(insert number):* One	
ii.	**Frequency of services.** The State requires *(select one)*:	
	O	The provision of waiver services at least monthly
	X	Monthly monitoring of the individual when services are furnished on a less than monthly basis. If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

O	Directly by the Medicaid agency
X	By the operating agency specified in Appendix A
O	By an entity under contract with the Medicaid agency. *Specify the entity*:
O	Other (*specify*):

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

QMRPs (persons with bachelor's degree in social services and one year experience) and RNs who are licensed in the District of Columbia.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The applicant must meet one of the following criteria and be eligible to receive the services provided in an ICF:

Option A: The applicant's primary disability is mental retardation with an intelligence quotient (IQ) of 59 or less.
Option B: The applicant's primary disability is mental retardation with an intelligence quotient (IQ) of 60-69 and the applicant has at least one of the handicapping conditions listed below OR applicant's primary disability is mental retardation with an intelligence quotient (IQ) of 60-69 and the applicant has severe functional limitations in at least three of the major life activities listed below.
Option C: The applicant is eligible under the category of developmental disabilities such as autism, cerebral palsy, Prader Willi or spinal bifida and the applicant has severe functional limitations in at least three of the major life activities listed below.

HANDICAPPING CONDITIONS are defined as:

Mobility refers to the ability to move form one area to another area independently. The need for assistive devises does not indicate that the individual is non-mobile, but the assistive devices should be noted.

Sensory Deficits refers to an individual lacking ability to translate into consciousness the effects of a stimulus. Sense of:

Chronic Health is a long-term progressive demise in health to include but not limited to the following diagnosis: Cancer, Renal failure, COPD and Multiple Sclerosis

Behavior Problems refers to an individual's need for supervion to ensure their safety or the safety of others.

MAJOR LIFE ACTIVITIES are defined as:

Self-Care Skills: Self-care skills refer to the effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected of their age and cultural group. Self-care skills include personal skills essential for privacy and independence.

Language: Understanding and use of language refers to the development of both verbal and nonverbal and receptive and expressive communication skills.

Functional Academics: Functional Academics refers to the development of those processes by which information received by the senses is stored, recovered and used. It includes the development of the processes and abilities involved in memory, reasoning and problem solving.

Self-Direction: Self-direction refers to the independent ability to engage in a direct course of thought and action; to engage in motivated, purposeful actions. For example, an individual who can reliably and independently locate leisure time materials and use them in a normative manner would be

characterized as processing a high degree of self-direction.

Capacity for Independent Living: Capacity for independent living refers to the ability to provide for one's own custody. The capacity for independent living involves the degree to which there is a probability of physical impairment or injury to the residence or another individual due to violent behavior or impaired judgment. The determination of an individual's capacity for independent living may (or may not be) affected by limitations in self-care skills, learning and self-direction the individual may have.

Health and Safety: Health and Safety refers to an individual's ability to ensure their own safety in the event of an emergency situation such as in the event of fire, illness, injury or severe weather.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

X	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
O	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation. Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Initial Evaluation: When an individual applies for DDS services, a case manager meets with them and discusses the choice of ICF-MR versus waiver services. The applicant is interviewed with the purpose of completing and eligibility worksheet and is also presented with a Bill of Rights and Responsibilities document. The case manager submits the Eligibility Worksheet and the most recent medical, psychological and social evaluations along with the applicant's completed Freedom of Choice to the Eligibility Specialist in the DDS Waiver Unit. The Eligibility Specialist determines the applicant's eligibility by applying the Level of Care criteria listed in B.6.d above. The case manager is responsible for assisting the applicant in gathering all collateral information necessary to determine eligibility. If the applicant is denied waiver eligibility, the case manager contacts the applicant and offers assistance to the applicant in exercising their appeal rights.

Re-evaluation: The DDS QMRP/RN determines that there is a reasonable indication that the participant, but for the provision of waiver services would need services in an ICF/MR. The QMRP/RN determines this by completing a form that records that the participant requires assistance due to at least one of the following limitations:

1. Has a physical or medical disability requiring substantial and/or routine assistance as well as habilitative training in performing self-care and daily activities; or
2. Has deficits in self-care and daily living skills requiring habilitative training; or
3. Has a maladaptive social and/or interpersonal behavior patterns to the extent that he/she is incapable of conducting self-care or activities of daily living without habilitative training.

This determination is made through a planning and support team process based on comprehensive professional assessments, evaluations and/or reports that are on file in the Case Record.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

O	Every three months
O	Every six months
X	Every twelve months
O	Other schedule (*specify*):

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

X	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
O	The qualifications are different. The qualifications of individuals who perform reevaluations are *(specify)*:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify)*:

DDS hosts an on-line certification roster that has trigger dates that cue the DDS Case Manager and Waiver Unit that a re-evaluation is due. If a re-evaluation has not been conducted within 30 days of the due date, an email is automatically generated by the on-line certification roster system that notifies the DDS Case Manager and the Waiver Unit that the re-evaluation is overdue. It is the responsibility of the Chief of the DDS Waiver Unit to ensure that re-evaluations are conducted in a timely fashion.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Records are maintained at the DDS Waiver Unit and the Medical Assistance Administration. Records are maintained at each of these locations for at least three years.

Appendix B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Participants are notified of the choice of either institutional or Home and Community Based Services at their initial meeting with their assigned Case Manager. At that meeting, they are also provided with a brochure that gives information regarding all of the District providers. The Case Manager assists the participant in choosing providers, including giving participants with sample questions they should ask prospective providers. If needed, Case Managers arrange phone calls and meetings for the participant and prospective providers.

The form signed by the participant or designee is entitled MEDICAL ASSISTANCE ADMINISTRATION HOME AND COMMUNITY BASED WAIVER PROGRAMS: ELIGIBILITY WORKSHEET and is provided to the participant/designee by the Case Manager. This form is available to CMS upon request.

b. Maintenance of Forms. Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Copies of the Beneficiary Freedom of Choice Documentation are maintained in:
- Medical Assistance Administration
- Department of Disability Services

The forms are maintained at these locations for a minimum of three years.

Appendix B-8: Access to Services by Limited English Proficient Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The Language Access Act of 2004, enacted by the City Council of the District of Columbia, requires that all District government programs, departments and services assess the need for, and offer, oral language services; provide written translations of documents into any non-English language spoken by a limited or no-English proficient population that constitutes 3% or 500 individuals, whichever is less, of the population served or encountered, or likely to be served or encountered; to ensure that District government programs, departments, and services with major public contact establish and implement a language access plan and designate a language access coordinator; to require that the Office of Human Rights coordinate and supervise District government programs, departments, and services in complying with the provisions of this act and establish the position of Language Access Director for this purpose; and to amend the District of Columbia Latino Community Development Act and to repeal the Bilingual Services Translation Act of 1977 to repeal redundant provisions.

Pursuant to the DC Municipal Regulation 4204.1, each provider of Waiver services shall establish a plan to adequately provide services to non- English speaking participants. The provider shall identify the necessary resources and individuals in order to implement the plan. Identification of necessary resources may include referring the recipient to another services provider agency or businesses with staff that is able to meet the particular language need of the recipient. DCMR 4204.2 mandates that when the referral of a non-English speaking recipient is made, the provider shall communicate (within 24 hours of the referral) the request to the appropriate case management service provider for approval. A written verification of the referral shall be sent to the case manager within 48 hours of the referral.

The District of Columbia Medical Assistance Administration and the Department of Disability Services offer information on language and interpreter services. DDS uses local government dollars to fund language and interpreter services for any public meetings.

Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	☐	
Homemaker	☐	
Home Health Aide	☐	
Personal Care	☐	
Adult Day Health	☐	
Habilitation	X	In-Home Supports
Habilitation	X	Supported Living
Residential Habilitation	X	
Day Habilitation	X	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	X	
Supported Employment	X	
Education	☐	
Respite	X	Center-Based Respite
Respite	X	Respite
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	X	Companion Care

Other Services *(select one)*	
○	Not applicable
X	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:

a.	Behavioral Supports
b.	Community Support Team
c.	Environmental Accessibilities Adaptations
d..	Host Home
e.	Nutrition
f.	One-Time Transitional Services
g.	Personal Emergency Response System (PERS)
h.	Professional Services
i.	Transportation – Vocational
j.	Transportation –Community Access
k.	Vehicle Modifications

Extended State Plan Services *(select one)*

O	Not applicable
X	The following extended State plan services are provided *(list each extended State plan service by service title)*:
a.	Dental
b.	OT
c.	PT
d.	Skilled Nursing
e.	Speech, Hearing and Language Therapy

Supports for Participant Direction *(select one)*

O	The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
X	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	☐	
Financial Management Services	☐	

Other Supports for Participant Direction *(list each support by service title)*:

a.	
b.	
c.	

b. Alternate Provision of Case Management Services to Waiver Participants. When case management is not a covered waiver service, indicate how case management is furnished to waiver participants *(check each that applies)*:

☐	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*
X	As an administrative activity. *Complete item C-1-c.*
☐	Not applicable – Case management is not furnished as a distinct activity to waiver participants. *Do not complete Item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

DDS directly employs Case Managers. All case management to waiver participants is provided by these DDS staff.

Appendix C-2: General Service Specifications

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services-*(select one)*:

X	**Yes**. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):
	a) All direct care providers including personal care aides, attendants, and respite care providers must undergo criminal background checks. (b) The scope of investigations includes a criminal background check at the District level (state level). (c) The process for ensuring that mandatory investigations have been conducted is a condition of participation for all Medicaid provider agencies. Annually a representative sample of personnel records are reviewed to ensure compliance. As a condition of participation in the Medicaid program each Home Health Care Agency shall ensure that each direct care provider has passed a criminal background check. Each direct care provider must always pass a criminal background check pursuant to the Health-Care Facility, Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238: D.C. official Code, § 44-551 et seq.) The (District) Metropolitan Police Department is the entity responsible for conducting all criminal background checks for staff of all agencies. The Medical Assistance Administration and the Department of Disability Services are responsible for reviewing a sample of all personnel records to ensure that the check is indeed conducted.
O	**No**. Criminal history and/or background investigations are not required.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry *(select one)*:

O	**Yes**. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
X	**No**. The State does not conduct abuse registry screening.

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one*:

O	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*
X	**Yes**. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Complete Items C-2-c.i –c.iii.*

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit
	Residential Habilitation	4-6
	Host Home	3
	Supported Living	3

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

All residences are located in the community. Rules for these residences require features compatible with the other residences in the surrounding neighborhood. Kitchens, bedrooms, bathrooms and other rooms are like those in typical homes. Participants have Plans of Care that include recreation and leisure activities and employment consistent with their needs and interests. Each participant must be assured reasonable privacy and adequacy of space, storage, furnishings, bathrooms and other needs. Participants are encouraged to reflect their personal preferences in decorating and furnishing their individual living spaces. Participants are actively involved in typical, normative daily routines of daily living to the extent of their capabilities including cooking, laundry, shopping and cleaning their rooms.

iii. Scope of Facility Standards. By type of facility listed in Item C-2-c-i, specify whether the State's standards address the following *(check each that applies)*:

Standard	Facility Type Residential Habilitation	Facility Type Host Home	Facility Type Supported Living	Facility Type
Admission policies	X	X	X	☐
Physical environment	X	X	X	☐
Sanitation	X	X	X	☐
Safety	X	X	X	☐
Staff : resident ratios	X	X	X	☐
Staff training and qualifications	X	X	X	☐
Staff supervision	X	X	X	☐
Resident rights	X	X	X	☐
Medication administration	X	X	X	☐
Use of restrictive interventions	X	X	X	☐
Incident reporting	X	X	X	☐
Provision of or arrangement for necessary health services	X	X	X	☐

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

X	**No**. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
O	**Yes**. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

O	The State does not make payment to relatives/legal guardians for furnishing waiver services.
X	The State makes payment to relatives/legal guardians under ***specific circumstances*** and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*

	For all waiver services, payments are **not** made to legal guardians, including a parent of a minor child, spouse, or legal guardian of an adult. Payments are made to relatives, which is defined as parent of an adult child, siblings, grandparents, aunts, uncles, cousins In order to receive payment for any waiver service, Relatives: 1. Must become an employee of the participant's chosen waiver-enrolled provider agency, OR 2. Must be an enrolled waiver service/Medicaid provider (agency or individual). The following waiver services may be offered by relatives: In-home supports; Companion Care; Host Home: Transportation- Community Access Transportation-Vocational Relatives may be paid for providing this service whenever the service specifications in Appendix C-3 are met for participants who are at least eighteen years of age. Relatives may serve as either the contracted worker or the chosen waiver enrolled agency, but not both. The relative must meet the same standards as other employees or contractors non-related to the participant. The relative contracted as the worker must be at least 18 years of age. The relative contracted as the worker is responsible for maintaining records in accordance with all District and provider requirements. A relative serving as a worker must meet all standards established by the District, and is responsible for duties as outlined in Appendix C-3 and accompanying waiver manual. Payment for services rendered are approved by prior and post authorization as outlined in the Plan of Care. All workers must be affiliated with a provider and are subject to all standard provider oversight described in this waiver application. Any indication that Medicaid guidelines are not being met leads to an investigation that may result in recoupments of payments to the provider.
O	Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
O	Other policy. *Specify*:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The following processes are used to assure that all willing and qualified providers have the opportunity to enroll as Waiver providers. All qualified waiver providers are accepted as providers of care. All criteria for Waiver providers are printed and available to any and all interested providers. This information is available on line as well as with the MAA and DDS Offices. Licensure Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached to the application packet..

The provider enrollment process is open to all willing and qualified providers. Each provider has the opportunity to enroll if they meet the approved qualified criteria (State/local and Federal criteria, e.g. District licensure requirements and requisite Code of Federal regulations for the provision of services) for provision of services for the DDS Waiver.

Providers have ready access to information regarding requirement and procedures to qualify. This can easily be done by connecting to the Internet and typing www.adrcdc.org. This site maintains all appropriate DDS Waiver provider and participant information for enrollment including contact persons. Additional information can be obtained by contacting the MAA-Office of Disability Aging and DDS Provider Relations Offices in person or by phone and staff will provide information and a provider application, as needed.

PROVIDER ENROLLMENT PROCESS:

1. Provider applications are submitted to the Fiscal Intermediary ACS, who in turn scans the application and submits the document to DDS.

2. DDS reviews all provider application packets for completion of request for provision of specific provider type, e.g. Residential Habilitation, Host Home, etc., as well as necessary signatures and billing information. DDS checks the application for Professional Licensure and credentials, for all professionals who request to provide services. Information such as Certification/Registration Specialty Information (e.g., Behavioral Support, Dental Practitioners, Transportation providers, Affiliations, Professional Liability Insurance Coverage, Malpractice Claims, History, Revoked or suspended licensure, DEA Numbers, Criminal History, drug use, suspension of Medicare/Medicaid, OSHA, sanctions from a regulatory agency and business ownerships. The application is reviewed for:

- A description of ownership and a list of major owners
- A list of Board members and their affiliations:
- A roster of key personnel, their qualifications and a copy of their positions descriptions
- Copies of licenses and certifications for all staff providing medical services
- The address of all sites at which services will be provided to Medicaid participant
- Copy of the most recent audited financial statement of the organization
- A completed copy of the basic organizational documents of the provider, including any organizational chart and current articles of the incorporation
- A copy of the by-laws or similar documents regulating conduct of the provider's internal affairs
- A copy of the business license
- The submission of any other documentation deemed necessary by DDS for the approval process as a Medicaid Provider. Additional requirement are Quality Improvement Plan, Admission process, Code of conduct, Policies and procedures, agency complaint process.

- Credentials of the health care professionals (current), appropriateness of projected provision of services
- Sufficient capital and funding to support provision of services. They also provide/ determine the rate structure for nursing facilities out of state.
- The DDS Office of Program Integrity reviews the application for Quality Improvement plans, risk assessment/ mitigation plans, policies on safety and security, emergency plans.

If DDS officials approve the application as submitted then the entire document is sent to the Medical Assistance Administration, Office on Disabilities and Aging. The original is sent to the Office of Program Operations where a permanent provider number is issued and notification letter of approval is mailed.

If the application is rejected because of insufficient information the provider is given thirty days to submit the appropriate information. When requested information is not submitted to DDS within the specified timeframe, the application is returned to the provider as it is assumed they no longer interested in providing services for the District of Columbia. The provider however, is given the opportunity to submit another application if they are so inclined.

When the application is approved there is a Mandatory Provider orientation conducted by MAA/ODA for programmatic and billing services. The orientation by MAA/ODA consists of all policies and procedures of the DDS waiver program and review of requisite rules. A billing manual is provided during the orientation and a class is scheduled and conducted by ACS.

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Behavioral Supports
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
O	Service is included in approved waiver. There is no change in service specifications.
O	Service is included in approved waiver. The service specifications have been modified.
X	Service is not included in the approved waiver.

Service Definition (Scope):

Clinical and therapeutic services that assist informal support persons and/or paid support staff in carrying out individual positive behavioral support plans, which are not covered by the Medicaid State Plan, necessary to improve the individual's independence and inclusion in their community. Behavioral Support activities are provided by professionals in psychology, counseling and behavior management. The service may include assessment of support needs, the development of a home-based positive behavioral support plan, training to carry out the plan and monitoring of the participant and the provider in the implementation of the plan. This service is available to all participants in the waiver.

In the assessment process, Behavioral Supports personnel collect data, review documentation, conduct observations, interview family or staff, assist with functional assessments/analyses, and other duties as needed to conduct a full assessment. Behavioral Supports personnel's role in the implementation of behavior support plans includes training participants, family, staff and others in behavioral strategies and other specific topics. This staff may also model the application of procedures, conduct integrity observations, provide supportive or corrective feedback concerning plan implementation and directly implement plans.

Behavioral Supports personnel must communicate effectively with the participant, the participant's Case Manager, the Community Supports Team (if applicable) and other stakeholders to assure that supports and treatments are well-coordinated for the participant and integrated into the participant's Plan of Care.

Minimum qualifications to draft positive behavior plan is Master's degree in psychology when supervised by a licensed psychologist or a licensed clinical social worker. Minimum qualifications for consultation are Masters level psychologist, advanced practice nurse, LCSW, LGSW and licensed professional counselor or closely related field, and at least one year experience serving people with developmental disabilities. Knowledge and experience in behavioral analysis is preferred.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
		Psychologist		Core Service Agencies
		Behavior Specialist		Group Home for Mentally Retarded Persons
		Psychiatrist		Supported Living Provider
		Licensed Clinical Social Worker		
		Licensed Graduate Social Worker		

	Licensed Professional Counselor	
	Certified Alcohol Counselor	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian (see C-2.e.)

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Psychologist	District of Columbia Municipal Regulation Title 17, Chapter 69/ Psychology	Not required	
Behavior Specialist		Not required	District of Columbia Municipal Regulation Title 17, Chapter 69/ Section 6911/ Psychology
Psychiatrist	§ 302(14) of the District of Columbia Health Occupations Revision Act of 1985, D.C. Law 6-99, D.C. Code § 2-3303.2(14) (1981 Ed.); and Mayor's Order 86-110, dated July 18, 1986		
Licensed Clinical Social Worker	DCMR Title 17, Chapter 70/Social Worker	Not required	
Licensed Graduate Social Worker	DCMR Title 17, Chapter 70/Social Worker	Not required	
Licensed Professional Counselor	DCMR Title 17, Chapter 66/Professional Counselor		
Certified Alcohol Counselor	XXX	XXX	XXX
Core Service Agencies			DMH Certified Community Based Mental Health Rehabilitation Services provider entered into Human Care Agreement with Department of Mental Health
Group Home for Mentally Retarded	DCMR Title 22, Chapters 13-17		

Persons			
Supported Living			Provider enrolled to provide services through DDS and has current Medicaid agreement. For individual employees, the following requirements apply: Documentation that each employee is eighteen (18) years of age or older; Documentation that each employee was found acceptable by the participant; Annual documentation from a physician or other official that employee free from communicable disease as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin Test; Record of completion of competency based training in communication with people with intellectual disabilities; Record of completion of competency based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030; A high school diploma or general equivalency development; (GED) certificate from English speaking program or ESL certificate; Record of completion of competency based training in emergency procedures; Certification (annual) in cardiopulmonary resuscitation (CPR) and First Aid; Record of completion of DDS approved pre-service and in-service training in DDS policies and procedures; Training needed to address the unique support needs of the participant as detailed in their Plan of Care; and Record of criminal background check

			consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13,2002 (D.C. Law 14-98; D.C. Official Code, $5 44-55 1 et seq.).

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual Providers	DDS	On-going through claims processing
Supported Living/Group Home for Mentally Retarded Persons	DDS	On-going through claims processing
Core Service Agency	Department of Mental Health	xxxxxx

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed	**X**	Provider managed

Service Specification

Service Title:	**Center-Based Respite**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

O	Service is included in approved waiver. There is no change in service specifications.
X	Service is included in approved waiver. The service specifications have been modified.
O	Service is not included in the approved waiver.

Service Definition (Scope):

Supports and services provided for relief of those unpaid individuals normally providing care to individuals unable to care for themselves, furnished on a short term basis, by a DDS-authorized respite facility.

In the event of a crisis, respite can be delivered by a licensed residential habilitation provider authorized to provide Center-Based Respite in a residential habilitation program.

These services are necessary to prevent individuals from being institutionalized or sent to an out-of-District program.

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the District that is not a private residence.

Respite care will ensure that participants have access to community activities as delineated in the participant's

Plan of Care. Community activities, including transportation to and from these activities, are included in the rate for Center-Based Respite. These activities include school attendance, or other school activities, or other activities the individual would receive if they were not in the center-based respite facility. These community activities would allow the individual's routine not to be interrupted.

Center Based Respite is not available to participants receiving Companion Care, Host Home, Supported Living or Residential Habilitation services. Settings in which the provider is compensated for the general care of the participant (such as a group home, ICR/MR, etc.) cannot be reimbursed for respite care services related to the residents of the facility.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limited to 720 hours or 30 days per participant, per Plan of Care year. The date of the service authorization shall start the one-year period. Services provided cannot exceed those authorized in the plan of care. Any request for hours in excess of 720 hours must have DDS approval with proper justification and documentation.

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Center-Based Respite Care
				Group Home for Mentally Retarded Persons
				Supported Living Provider

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Center-Based Respite			Provider enrolled to provide services through DDS and has current Medicaid agreement. For individual employees, the following requirements apply: Documentation that each employee is eighteen (18) years of age or older; Documentation that each employee was found acceptable by the participant; Annual documentation from a physician or other official that employee free from communicable disease as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin Test; Record of completion of competency based training in communication with people with intellectual disabilities;

			Record of completion of competency based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030; A high school diploma or general equivalency development; (GED) certificate from English speaking program or ESL certificate; Record of completion of competency based training in emergency procedures; Certification (annual) in cardiopulmonary resuscitation (CPR) and First Aid; Record of completion of DDS approved pre-service and in-service training in DDS policies and procedures; Training needed to address the unique support needs of the participant as detailed in their Plan of Care; and Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13,2002 (D.C. Law 14-98; D.C. Official Code, $5 44-55 1 et seq.).
Group Homes for Mentally Retarded Persons	Ch 35 of Title 22 of the District of Columbia Municipal Regulations- "Licensure of Group Homes for Mentally Retarded Persons"		

Supported Living Provider			Provider enrolled to provide services through DDS and has current Medicaid agreement. For individual employees, the following requirements apply: Documentation that each employee is eighteen (18) years of age or older; Documentation that each employee was found acceptable by the participant; Annual documentation from a physician or other official that employee free from communicable disease as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin Test; Record of completion of competency based training in communication with people with intellectual disabilities; Record of completion of competency based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030; A high school diploma or general equivalency development; (GED) certificate from English speaking program or ESL certificate; Record of completion of competency based training in emergency procedures; Certification (annual) in cardiopulmonary resuscitation (CPR) and First Aid; Record of completion of DDS approved pre-service and in-service training in DDS policies and procedures; Training needed to address the unique support needs of the participant as detailed in

			their Plan of Care; and Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13,2002 (D.C. Law 14-98; D.C. Official Code, $5 44-55 1 et seq.)

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Agency	DDS	Initially, annually and as necessary

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification

Service Title:	**Community Support Team**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
O	Service is included in approved waiver. There is no change in service specifications.
X	Service is included in approved waiver. The service specifications have been modified.
O	Service is not included in the approved waiver.

Service Definition (Scope):

Community Support Teams (CSTs) provide intensive behavioral and psychiatric supports for people in the community who are at imminent risk of institutionalization. The CST is a specialized professional treatment team that consists of a psychologist, a psychiatrist, a registered nurse, a social worker, and a Certified Alcohol Counselor and behavior specialist as needed. Each member is involved collaboratively in the development of an inter-disciplinary plan. The most clinically appropriate team member(s) represents the team in providing direct service to the participant. Each member is involved as needed, but team member(s) will spend a minimum of one hour weekly meeting with the participant and/or care givers at the onset of treatment and will review summary data at least weekly with CST staff who are involved. Written behavioral support strategies will be reviewed and updated at least monthly, based on the participant's response to services.

CST uses a collaborative, inter-disciplinary approach to develop individualized behavioral and psychiatric strategies that are both person-centered and effective. Supports and services available through the CST include psychological evaluations, psychosocial assessments, psychiatric evaluations, medical screenings, intensive formalized positive behavioral supports, psychiatric treatments, family and/or agency training, service transition

planning, brief counseling therapies, 24-hour on-call phone supports, and crisis planning. The team also works closely with case managers to assure a coordinated team effort when other professionals in the community are providing supports (e.g., neurologist, general physician, physical therapist).

The following criteria must be present to receive CST supports:

1. An ongoing pattern of behavior that includes physical harm to self or others and /or behaviors/psychiatric symptoms which have led to institutionalization in the past or have a high probability of resulting in institutionalization. (e.g., self-injurious behavior, physical aggression, illegal or inappropriate sexual acts, reckless endangerment, psychiatric conditions leading to the denial of self-preservation or extremely poor hygiene).
2. An imminent risk of institutionalization;
3. A need for 24 hour on-call phone supports and crisis planning to support health and safety.

CST services do not include onsite crisis intervention services and cannot adequately serve people who threaten or attempt suicide or homicide or who have a pattern of felony violations involving violence or the victimization of others.

CST personnel will have a minimum of 2 years experience providing professional services to people with developmental disabilities or receive supervision by professional staff that have the requisite experience. Psychologists will provide clinical leadership and provide supports consistent with person-centered practices and positive behavioral support practices.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Core Service Agencies
				Home Health Agencies
Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Core Service Agency	Not required	Not required	DMH Certified Community Based Mental Health Rehabilitation Services provider entered into Human Care Agreement with Department of Mental Health
Home Health Agencies	Health-Care and Community Residence Facility Act, Hospice and Home-Care Licensure Act of 1983, effective Feb. 24, 1984 (DC Law		

	5-48; DC Official Code, § 44-501 et seq), and implementing rules.		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Core Service Agency	DMH	Initially, annually and as necessary
Home Health Agencies	Department of Health: Health Regulation Administration	Initially, annually and as necessary

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification

Service Title:	**Companion Care**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

O	Service is included in approved waiver. There is no change in service specifications.
O	Service is included in approved waiver. The service specifications have been modified.
X	Service is not included in the approved waiver.

Service Definition (Scope):

Companion Care services are provided in a participant's home by a principal care provider (Companion) who ives as a room mate with the participant. Companion Care services are furnished to adults who require someone o assume 24 hour as-needed responsibility for their physical and social well-being as determined by a District- nanaged assessment process and Plan of Care. This service differs from Host Home in that the participant lives n his own home (rented or owned) and does not require 24 hour direct supervision. The Companion assists in mplementing the needed supports as identified in the Plan of Care which enable the participant to retain or mprove skills related to health, activities of daily living, money management, community mobility, recreation, cooking, shopping, use of community resources, community safety and other adaptive skills needed to live in the community. Community access activities and coordination of transportation services are provided as needed by he principal Companion. The Companion is responsible for coordinating and assisting as needed with ransportation to medical appointments. The Companion is responsible for providing medical and physical ıealth care that can be delivered by unlicensed persons in accordance with the District's Nurse Practice Act.

Companion Care services can be provided by a person (s) unrelated to the participant or a family member but not a parent, spouse or legally responsible relative. The Companion is responsible for participating in and abiding by the Plan of Care as well as maintaining records in accordance with District and provider requirements.

Companion Care services are arranged by provider organizations that are subject to licensure and are subject to standards identified by the District and the provider. The provider organization has 24 hour responsibility for arranging and overseeing the delivery of services, providing emergency services as needed and providing or arranging for two weeks of respite per year. The participant's home receives an initial inspection by the

provider organization as well as periodic inspections with a frequency determined by the provider. The provider will make a minimum of once per month contact with the Companion.

The Companion will receive free rent.

A written agreement developed as part of the participant's Plan of Care will define all shared responsibilities between the Companion and the participant including no more than four hours per day of support provided by the Companion, activities provided by the Companion, a typical weekly schedule and payment for both parties' personal needs, utilities and food. Revisions to this agreement must be done by the Plan of Care Team and can occur at any time at the request of the participant, the Companion or the provider.

Separate payment will not be made for Host Home, Residential Habilitation, Supported Living, Center-Based Respite or In-Home Supports, since these services are integral to and inherent in the provision of Companion Care services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Group Homes for Mentally Retarded Persons
				Supported Living Provider

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	X	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Group Homes for Mentally Retarded Persons	Ch 35 of Title 22 of the District of Columbia Municipal Regulations- "Licensure of Group Homes for Mentally Retarded Persons"		For individual employees, the following requirements apply: Documentation that each employee is eighteen (18) years of age or older; Documentation that each employee was found acceptable by the participant; Annual documentation from a physician or other official that employee free from communicable disease as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin Test; Record of completion of competency based training in communication with people with intellectual disabilities; Record of completion of competency based training in infection control procedures consistent with the requirements of the Occupational Safety and Health

			Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030; A high school diploma or general equivalency development; (GED) certificate from English speaking program or ESL certificate; Record of completion of competency based training in emergency procedures; Certification (annual) in cardiopulmonary resuscitation (CPR) and First Aid; Record of completion of DDS approved pre-service and in-service training in DDS policies and procedures; Training needed to address the unique support needs of the participant as detailed in their Plan of Care; and Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13,2002 (D.C. Law 14-98; D.C. Official Code, $5 44-55 1 et seq.).
Supported Living Provider			Provider enrolled to provide services through DDS and has current Medicaid agreement. For individual employees, the following requirements apply: Documentation that each employee is eighteen (18) years of age or older; Documentation that each employee was found acceptable by the participant; Annual documentation from a physician or other official that employee free from communicable disease as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin Test; Record of completion of competency based

			training in communication with people with intellectual disabilities; Record of completion of competency based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030; A high school diploma or general equivalency development; (GED) certificate from English speaking program or ESL certificate; Record of completion of competency based training in emergency procedures; Certification (annual) in cardiopulmonary resuscitation (CPR) and First Aid; Record of completion of DDS approved pre-service and in-service training in DDS policies and procedures; Training needed to address the unique support needs of the participant as detailed in their Plan of Care; and Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13,2002 (D.C. Law 14-98; D.C. Official Code, $5 44-55 1 et seq.)

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Agency	DDS	Initially, annually and as necessary

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification

State:	
Effective Date	

Service Title:	**Day Habilitation Services**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
O	Service is included in approved waiver. There is no change in service specifications.
X	Service is included in approved waiver. The service specifications have been modified.
O	Service is not included in the approved waiver.

Service Definition (Scope):

Day Habilitation Services are aimed at developing activities and/or skills acquisition to support or further community integration opportunities outside of an individual's home that promote independence, autonomy and assist him/her in developing a full life in his/her community. Services should focus on habilitation activities in group settings that enable the participant to attain maximum functional level based on his or her valued outcomes. These services should be provided in a variety of community venues and the venues should routinely correspond with the context of the skill acquisition activity to enhance the habilitation activities. Overarching goals of the program shall include regular community inclusion and the opportunity to build towards maximum independent status for the individual.

The primary focus of Day Habilitation Services is acquisition of new skills or maintenance of existing skills based on individualized preferences and goals. The skill acquisition/maintenance activities should include formal strategies for teaching the individualized skills and include the intended outcome for the participant. Individualized progress for the skill acquisition/maintenance activities should be routinely reviewed and evaluated with revisions made as necessary to promote continued skill acquisition. As a person develops new skills, his or her training should move along a continuum of habilitation services offered toward greater independence and self-reliance.

Day Habilitation Services shall focus on enabling participants to attain their maximum functional level and shall be coordinated with any physical, occupational or speech therapies listed in the individual's Plan of Care. In addition Day Habilitation Services may serve to reinforce skills or lessons taught in school, therapy or other settings.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is delivered no more than eight hours per day. Provisions must be made by the provider for participants who arrive early and depart late.

Time spent in transportation to and from the program shall not be included in the total amount of services provided per day.

Time spent in transportation to and from the program for the purpose of training the participant on the use of transportation services may be included in the number of hours of services provided per day for a period of time specified in the Plan of Care.

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	**X**	Agency. List the types of agencies:
				Day Habilitation

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications *(provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Day Habilitation			Agencies must operate in accordance with DCMR Title 29, Section 945 Day Habilitation Services

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Agency	DDS	Initially, annually, and as necessary

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification

Service Title:	**Dental Services**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

X	Service is included in approved waiver. There is no change in service specifications.
O	Service is included in approved waiver. The service specifications have been modified.
O	Service is not included in the approved waiver.

Service Definition (Scope):

Dental services shall include: Oral examinations; radiographs; tests and laboratory examinations; preventative services including, dental prophylaxis, topical fluoride treatment, space maintenance and sealant; restorative services including, amalgam, resin-based, inlay/on lay, crowns, and other restorative services; endodontics including, pulp capping, pulpotomy, endodontic therapy and endodontic retreatment; periodontics including, a comprehensive oral examination, surgical services, scaling and root planning, full mouth debirement and periodontal maintenance procedures; prosthodontics-removable including, complete and partial dentures, adjustments, repairs of dentures, rebase and reline procedures and interim prosthesis and tissue conditioning; prosthodontics-fixed including, denture pontics, crowns and other services; oral and maxillofacial surgery including extractions local anesthesia, suturing and routine postoperative care; emergency treatment of dental pain; anesthesia including full mouth rehabilitation or other services provided under intravenous sedation or general anesthesia; orthodontics limited to medically or habilitatively necessary procedures; hospitalization clinically necessary to perform dental procedures; home visits clinically necessary to perform dental procedures; and professional consultation.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) *(check one or both)*:	**X**	Individual. List types:		Agency. List the types of agencies:
	Dentists			

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person		Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Dentist	§302(14) of the District of Columbia Health Occupations Revision Act of 1985, D.C. Law 6-99, D.C. Code §2-3303.2(14) (1988 Repl. Vol.), 33 DCR 729, 732 (February 7, 1986), and Mayor's Order 86-110, 33 DCR 5220 (August 22, 1986).		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Dentists	DDS	Ongoing through the claims process

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification

Service Title:	**Environmental Accessibilities Adaptations**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
O	Service is included in approved waiver. There is no change in service specifications.
X	Service is included in approved waiver. The service specifications have been modified.
O	Service is not included in the approved waiver.

Service Definition (Scope):

Those physical adaptations to the home or vehicle, required by the participant's Plan of Care, which are necessary to ensure the health, welfare and safety of the participant, or which enable the participant to function with greater independence in the home, and without which, the participant would require institutionalization. Home modification funds are not intended to cover basic construction cost. Waiver funds can be used to cover

the difference between constructing a bathroom and building an accessible or modified bathroom, but in any situation must pay for a specific approved adaptation.

Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the participant. Modifications may be applied to rental or leased property with the written approval of the landlord and approval of DDS. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, central air conditioning, exterior fencing, general home repair and maintenance, etc. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable District building codes.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A cap of $10,000 for a five year period for this service will be per participant. On a case by case basis, with supporting documentation and based on need, a participant may be able to exceed this cap with the approval of DDS and with the limits beyond the capped prior authorized. No more than two residences modified in a five year period; exceptions may be approved by DDS.

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	☐	Agency. List the types of agencies:
		Building Contractors		

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Building Contractor	Contractor's Basic Business License issued by the District of Columbia Department of Consumer and Regulatory Affairs		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Building Contractor	DDS	Initially for enrollment of providers

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Host Home**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

O	Service is included in approved waiver. There is no change in service specifications.
O	Service is included in approved waiver. The service specifications have been modified.
X	Service is not included in the approved waiver.

Service Definition (Scope):

Host Home services enable participants to retain or improve skills related to health, activities of daily living, money management, community mobility, recreation, cooking, shopping, use of community resources, community safety and other adaptive skills needed to live in the community. Host Home services are provided in a private home by a principal care provider who lives in the home and either rents or owns the home. Host Home services are furnished to waiver participants who require 24 hour services as determined by a District-managed assessment process and Plan of Care. Residential, community integration and transportation services are delivered in conjunction with residing in the home. The Host Home is responsible for providing transportation to medical appointments and providing medical and physical heath care that can be provided by unlicensed persons in accordance with the District of Columbia's Nurse Practice Act.

The total number of participants (including those served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed three. Host Home services are provided by a person (s) unrelated to the participant or a family member but not a parent, spouse or legally responsible relative. The Host Home is responsible for participating in and abiding by the Plan of Care as well as maintaining records in accordance with State and provider requirements.

Host Home services are arranged by provider organizations that are subject to licensure. Host Homes are subject to standards identified by the District and the provider. The provider organization has 24 hour responsibility for arranging and overseeing the Host Home, providing emergency services as needed and providing or arranging for 14 days of respite per year. The Host Home receives an initial inspection by the provider organization as well as periodic inspections with a frequency determined by the provider but is not subject to licensure.

Host Home contractors serving children who are waiver participants are required to provide daily supports and supervision, to meet on-going support needs and to handle emergencies as required on a 24-hour basis; just as any family would do for their minor child based on age, capabilities, health conditions and any special needs.

Host Home contractors serving adult waiver participants who are competent majors are required to be available for daily supervision, support needs or emergencies as outlined in the adult participant's Plan of Care based on medical, health and behavioral needs, age, capabilities, and any special needs.

Host Home contractors serving adult waiver participants who have been adjudicated incompetent are required to be available for daily supervision, support needs or emergencies as outlined in the adult participant's Plan of Care based on medical and behavioral needs, capabilities, age and special needs, and in accordance with the

legal requirements of the guardianship.

Host Home contractors must afford participants with a family atmosphere and a welcoming, safe and nurturing home expected in a family home environment. They assist participants in meeting their basic adaptive living needs offering direct support where required. Responsibilities of a Host Home contractor also extend beyond these basic duties of assuring health and safety. They help participants to develop their leisure interests and activities in the home setting and their relationships with other members in the household. In addition, they provide other supports consistent with the participant's goals, Plan of Care and identified support needs. They utilize specific teaching strategies to encourage independence and autonomy when a part of the participant's Plan of Care.

Host Home contractors support participants in accessing community services, activities and in pursuing and developing recreational and social interests outside the home. They facilitate participants in becoming a part of their communities and assist with teaching community living skills as outlined in the Plan of Care to achieve the participant's goals concerning their community and social life as well as to maintain contacts with their biological families and natural supports as specified in their Plans of Care.

For participants who are working or interested in working, Host Home contractors assist the participants, their provider agency, and other service entities in their attempts to locate an appropriate job and support the participant's desire to work. They maintain contact with supported employment or pre-vocational providers and employers where appropriate. Host Home contractors are responsible for assisting participants in keeping medical and therapy appointments and are expected to attend these appointments when their support is beneficial. They are responsible for providing for or ensuring transportation to school, work, and medical/therapy appointments. Host Home contractors who are engaged in employment outside the home should adjust these duties to allow the flexibility needed to meet their responsibilities to the participant.

Host Home contractors assist with the development of the Plan of Care well as maintaining records in accordance with State and provider requirements. They provide special medical supports specified in the Plan of Care as allowable under state law. Host Home contractors follow behavior support strategies as outlined in the participant's Plan of Care. Host Home contractors keep and provide information/data to assist in evaluating the participant's personal goals. They are responsible for immediately reporting to their agencies any major issues or concerns related to the participant's safety and well-being. Specialized training may be required to provide supports in a Host Home setting. This is determined by the provider agency, DDS and the participant's needs as identified in the Plan of Care.

Waiver payments are not made for room and board.

For individuals receiving Host Home services, separate payment will not be made for Center Based Respite or Respite since these services are integral to and inherent in the provision of Host Home services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) *(check one or both)*:		Individual. List types:	X	Agency. List the types of agencies:
				Group Homes for Mentally Retarded Persons
				Supported Living Provider

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	X	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Group Homes for Mentally Retarded Persons	Ch 35 of Title 22 of the District of Columbia Municipal Regulations- "Licensure of Group Homes for Mentally Retarded Persons"		For individual employees, the following requirements apply: Documentation that each employee is eighteen (18) years of age or older; Documentation that each employee was found acceptable by the participant; Annual documentation from a physician or other official that employee free from communicable disease as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin Test; Record of completion of competency based training in communication with people with intellectual disabilities; Record of completion of competency based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030; A high school diploma or general equivalency development; (GED) certificate from English speaking program or ESL certificate; Record of completion of competency based training in emergency procedures; Certification (annual) in cardiopulmonary resuscitation (CPR) and First Aid; Record of completion of DDS approved pre-service and in-service training in DDS policies and procedures;

			Training needed to address the unique support needs of the participant as detailed in their Plan of Care; and Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13,2002 (D.C. Law 14-98; D.C. Official Code, $5 44-55 1 et seq.).
Supported Living Provider			Provider enrolled to provide services through DDS and has current Medicaid agreement. For individual employees, the following requirements apply: Documentation that each employee is eighteen (18) years of age or older; Documentation that each employee was found acceptable by the participant; Annual documentation from a physician or other official that employee free from communicable disease as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin Test; Record of completion of competency based training in communication with people with intellectual disabilities; Record of completion of competency based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030; A high school diploma or general equivalency development;

			(GED) certificate from English speaking program or ESL certificate; Record of completion of competency based training in emergency procedures; Certification (annual) in cardiopulmonary resuscitation (CPR) and First Aid; Record of completion of DDS approved pre-service and in-service training in DDS policies and procedures; Training needed to address the unique support needs of the participant as detailed in their Plan of Care; and Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13,2002 (D.C. Law 14-98; D.C. Official Code, $5 44-55 1 et seq.)

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Agency	DDS	Initially, and annually thereafter

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**In-Home Supports**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
O	Service is included in approved waiver. There is no change in service specifications.
O	Service is included in approved waiver. The service specifications have been modified.
X	Service is not included in the approved waiver.

Service Definition (Scope):

In-Home Supports are provided to participants in order to assist them to reside successfully in homes owned or leased by the family or participant. These services are furnished to participants who live in a home that is leased or owned by the person(s) or their family receiving services. Services may be provided in the home or community, with the place of residence as the primary setting.

In-Home Supports focus on achieving one or more goals as outlined in the approved Plan of Care utilizing teaching and support strategies. Specified goals are related to acquiring, retaining and improving independence, autonomy and adaptive skills. Examples of trainings include the following:

- Self-help skills include activities of daily living and self-care. In-Home Supports provide direct support services to assist with these goals.
- Socialization skills are intended to foster community inclusion and well-being. An example is becoming involved in community recreational and leisure activities. In-Home Supports may provide out-of-home support, community-integration planning (event/location identification and scheduling), transportation, travel training, or other supports needed for socialization skills development.
- Cognitive and Communication Tasks Adaptive Skills may include homemaker tasks, safety skills, recognition of basic concepts, academic skills, and a variety of interpersonal communication objectives. In-Home Supports providers may work collaboratively with informal supports, the Case Manager and service providers to identify goal areas that tie in with the participant's choice of daily routine.
- Replacement Behavior Components of Positive Behavior Support Plans include those skills required to effectively address situations and antecedents of frequently occurring maladaptive or challenging behavior. In-Home Supports providers may work as directed by an assigned professional to assist the participant to develop skills necessary to reduce or eliminate episodes in which the participant becomes a danger to self or others.

Payment will not be made for routine care and supervision that is normally provided by the family or for services furnished to a minor by the child's parent or step-parent or by a participant's spouse. Family members who provide In-Home Supports must meet the same standards as providers who are unrelated to the participant. Payment does not include room and board or maintenance, upkeep and improvement of the participant's or family's residence.

Payment will not be made for travel or travel training to Supported Employment, Day Habilitation or Pre-Vocational Services.

This service includes 24-hour availability of response staff to meet schedules or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security.

In-Home Supports provide for therapeutic leave payment to enable the provider to retain personal care services during the time a participant is out of their home for a period if time in excess of 24 hours without direct care staff because if hospitalization, vacation or other absence. Therapeutic leave must be authorized and documented in the Plan of Care. This leave shall not exceed 14 days per year.

In-Home Supports are not available to participants receiving Host Home, Companion Care, Residential Habilitation or Supported Living services.

Qualified participants may use In-Home Supports in combination with State Plan Personal Care and Home Health Services as long as services are not provided during the same period in a day. The Case Manager is responsible for ensuring that no duplication of service occurs.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Eight hour limit per 24-hour day. DDS can authorize increase in hours in the event of a temporary emergency need for which there is no other resource available or demonstrated need based on DDS-authorized utilization review process.

Provider Specifications				
Provider Category(s) *(check one or both)*:		Individual. List types:	X	Agency. List the types of agencies:
				Qualified Provider of In-Home Supports
Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	X	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Qualified Provider of In-Home Supports			Agencies enrolled as a Qualified Provider of In-Home Supports with DDS **For individual employees, the following requirements apply:** Documentation that each employee is eighteen (18) years of age or older Documentation that each employee was found acceptable by the client Annual documentation from a physician or other official that employee free from communicable disease as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin Test Record of completion of competency based training in communication with people with intellectual disabilities Record of completion of competency based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030. A high school diploma or general equivalency development (GED) certificate from English speaking program or ESL certificate; Record of completion of competency based training in emergency procedures Certification (annual) in cardiopulmonary resuscitation (CPR) and First Aid

			Record of completion of DDS approved pre-service and in-service training in DDS policies and procedures; Training needed to address the unique support needs of the participant as detailed in their Individual Support Plan; Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13,2002 (D.C. Law 14-98; D.C. Official Code, *§5* 44-55 1 et seq.).

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Agency		Initially, annually, and as necessary

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Nutrition**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
O	Service is included in approved waiver. The service specifications have been modified.
O	Service is not included in the approved waiver.
Service Definition (Scope):	
Nutrition services include dietary evaluation and consultation with participants or their care provider. Services are intended to maximize the participant's nutritional health.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Provider Specifications				
Provider Category(s) *(check one or both)*:	**X**	Individual. List types:	**X**	Agency. List the types of agencies:
	Dietetic/Nutrition Counselor		Home Health Agency	
Specify whether the service may be provided by *(check each that*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

State:	
Effective Date	

applies):				(see C-2.e.)

Provider Qualifications (*provide the following information for each type of provider):*

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual	Chapter 33-Sections 1-3305 and 2-3307 of the DC Health Occupations Revision Act (Department of Consumer and Regulatory Affairs, Occupational and Professional Licensing Administration).		
Home Health Agency	Health-Care and Community Residence Facility Act, Hospice and Home-Care Licensure Act of 1983, effective Feb. 24, 1984 (DC Law 5-48; DC Official Code, § 44-501 et seq), and implementing rules.		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual	DDS	Initially, and annually thereafter
Home Health Agency	Department of Health: Health Regulation Administration	Initially, and annually thereafter

Service Delivery Method

Service Delivery Method *(check each that applies):*		Participant-directed	**X**	Provider managed

Service Specification

Service Title:	Occupational Therapy
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
O	Service is included in approved waiver. The service specifications have been modified.
O	Service is not included in the approved waiver.

Service Definition (Scope):
Occupational Therapy services shall be designed to maximize independence, prevent further disability, and maintain health. These services should be provided in accordance with the participant's Plan of Care. All Occupational Therapy services should be monitored to determine which services are most appropriate to enhance the participant's well being and to meet the therapeutic goals. The State Plan Occupational Therapy service must be exhausted before accessing this waiver service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Occupational Therapist		Home Health Agency	

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian (see C-2.e.)

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual	Title 17, DCMR, Chapter 63, Occupational Therapy		
Home Health Agency	Health-Care and Community Residence Facility Act, Hospice and Home-Care Licensure Act of 1983, effective Feb. 24, 1984 (DC Law 5-48; DC Official Code, § 44-501 et seq), and implementing rules.		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual	DDS	Initially, and annually thereafter
Home Health Agency	Department of Health: Health Regulation Administration	Initially, and annually thereafter

Service Delivery Method

Service Delivery Method *(check each that applies)*:		Participant-directed	X	Provider managed

Service Specification	
Service Title:	**One-Time Transitional Services**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
O	Service is included in approved waiver. There is no change in service specifications.
O	Service is included in approved waiver. The service specifications have been modified.
X	Service is not included in the approved waiver.

Service Definition (Scope):

One-Time Transitional Services are non-recurring set-up expenses for participants who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the participant is directly responsible for their own living expenses. Allowable expenses are those necessary to enable a participant to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the participant's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; (f) necessary home accessibility adaptations; and, (g) activities to assess need, arrange for and procure need resources. One-Time Transitional Services are furnished only to the extent that they are reasonable and necessary as determining through the Plan of Care development process, clearly identified in the Plan of Care and the participant is unable to meet such expense or when the services cannot be obtained from other sources. One-Time Transitional Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

One time life time maximum service of $5,000 per participant. Service expenditures will be tracked by MMIS and DDS data files and through prior and post authorization records.

Provider Specifications

Provider Category(s) *(check one or both)*:		Individual. List types:	X	Agency. List the types of agencies:
				Business Entity

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Business Entity	Providers must possess any valid license or certification required by State or local law		Providers must have the capacity as verified by the participant and case manager provide items and services of sufficient quality to meet the need for which they are intended.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Agency	DDS	Ongoing through claims processing

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Personal Emergency Response System (PERS)**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
●	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Personal Emergency Response System (PERS) is an electronic device which enables certain participants at high risk of institutionalization to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. Trained professionals staff the response center. PERS services are available to those participants who live alone, or who are alone for significant parts of the day and have no regular caregiver for extended periods of time, and who otherwise would require extensive routine supervision.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Coverage of the PERS is limited to the rental of the electronic device. PERS services shall include the cost of maintenance and training the recipient to use the equipment. Reimbursement will be made for an installation fee for the PERS unit. A monthly fee will be paid for the maintenance of the PERS.	

Provider Specifications				
Provider Category(s) *(check one or both)*:	X	Individual. List types:	**X**	Agency. List the types of agencies: Personal Emergency response system Vendor
	Self-Employed Individual		Business Entity	
Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian
Provider Qualifications *(provide the following information for each type of provider)*:				
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*	

Agency	Medical personnel involved in this service must conform to the standards delineated in the District of Columbia Title 2, Chapter 33, Sections 1.2201 – 2.3312 of the DC Health Occupations Revision Act (Department of Consumer and Regulatory Affairs, Occupational and Professional Licensing Administration).	Not Applicable	PERS providers shall have a current license, certification, or registration with the District of Columbia as appropriate for the type of system being purchased. The provider shall also possess a current license to do business issued in accordance with the laws of the District of Columbia. The provider shall demonstrate knowledge of applicable standards of manufacture, design and installation.
Self-Employed Individual	Medical personnel involved in this service must conform to the standards delineated in the District of Columbia Title 2, Chapter 33, Sections 1.2201 – 2.3312 of the DC Health Occupations Revision Act (Department of Consumer and Regulatory Affairs, Occupational and Professional Licensing Administration).		PERS providers shall have a current license, certification, or registration with the District of Columbia as appropriate for the type of system being purchased. The provider shall also possess a current license to do business issued in accordance with the laws of the District of Columbia. The provider shall demonstrate knowledge of applicable standards of manufacture, design and installation.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Agency	DDS	Initially, and annually thereafter
Individual	DDS	Initially, and annually thereafter

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Physical Therapy**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
O	Service is included in approved waiver. The service specifications have been modified.
O	Service is not included in the approved waiver.

Service Definition (Scope):

Physical Therapy services shall be designed to maximize independence, prevent further disability, and maintain health. Physical Therapy services are designed to treat the identified physical dysfunction or the degree to which pain associated with movement can be reduced. These services should be provided in accordance with the participant's Plan of Care. All Physical Therapy services should be monitored to determine which services most appropriate to enhance the participant's well being and meet the therapeutic goals.

The State Plan Physical Therapy service must be exhausted before accessing this waiver service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Physical Therapist		Home Health Agency	

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian (see C-2.e.)

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Physical Therapist	Title 22 DCMR, Chapter 30		
Home Health Agency	Health-Care and Community Residence Facility Act, Hospice and Home-Care Licensure Act of 1983, effective Feb. 24, 1984 (DC Law 5-48; DC Official Code, § 44-501 et seq), and implementing rules.		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Physical Therapist	DDS	Initially and annually thereafter
Home Health Agency	Department of Health: Health Regulation Administration	Initially and annually thereafter

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed	**X**	Provider managed

Service Specification	
Service Title:	**Pre-Vocational Services**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

O	Service is included in approved waiver. There is no change in service specifications.
X	Service is included in approved waiver. The service specifications have been modified.
O	Service is not included in the approved waiver.

Service Definition (Scope):

Pre-vocational activities are delivered in either a group or individualized setting designed to assist a participant in acquiring and maintaining basic work-related skills necessary to acquire and retain competitive employment. Overall goals of the program include regular community inclusion and development of work skills and habits to improve the employability of the participant.

Services should be offered which engage participants in real and simulated employment tasks to determine their vocational potential. Services focus on teaching concepts and skills such as following directions, attending to task, task completion, problem solving and job safety skills. All Pre-Vocational services are to be reflective of the participant's Plan of Care directed toward habilitation and/or teaching a specific job skill.

The primary focus of Pre-Vocational Services is the acquisition of employment-related skills based on the participant's vocational preferences and goals. These activities should include initial assessments, adult education, formal strategies for teaching the skills and supporting the participant to achieve their intended outcomes through trials at various employment opportunities. Individualized progress for the activities should be routinely reviewed and evaluated with revisions made as necessary.

Pre-Vocational services are provided to participants who because of their disabilities need intensive ongoing support to perform in a paid work setting. In the event participants are compensated in the employment-related training services, pay must be in accordance with the United States Fair Labor Standards Act of 1985. Participants who express interest in working in a competitive job setting are supported to transition to a more appropriate vocational opportunity by the pre-vocational provider and the Case Manager.

Pre-Vocational services are not available to participants who are eligible to participate in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the Individuals with Disabilities Education Act, 20 U.S.C. 1401 (16) and (71).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services shall normally be furnished to a participant up to eight hours per day on a regularly scheduled basis, for one or more days per week unless provided as an adjunct to other day activities included in a participant's Plan of Care.

Time spent in transportation to and from the program shall not be included in the total amount of services

provided per day.

This service cannot be provided or billed for at the same hours on the same day as Day Habilitation or Supported Employment.

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Prevocational Habilitation Agency

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Prevocational Habilitation Agency			Chapter 9 of Title 29 of the District of Columbia Municipal Regulations

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Prevocational Habilitation Agency	DDS	Initially, annually, and as necessary

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Specification

Service Title:	**Professional Services**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
O	Service is included in approved waiver. There is no change in service specifications.
O	Service is included in approved waiver. The service specifications have been modified.
X	Service is not included in the approved waiver.

Service Definition (Scope):

Professional Services are direct services to participants, based on need, and specified in an approved Plan of Care.

Professional services offered are: Massage Therapy, Sex Therapy, Art Therapy, Dance Therapy, Drama Therapy, Fitness Trainer, Acupuncture and Music Therapy.

Professional services may be utilized to:

- Assist in increasing the individual's independence, participation, emotional well-being and productivity in their home, work and community

- Provide training or therapy to an individual and/or their natural and formal supports, necessary to either develop critical skills that may be self-managed by the individual or maintained according to the individuals needs,
- Perform assessments and/or re-assessments and recommendations
- Provide consultative services and recommendations
- Provide necessary information to the individual, family, caregivers, and/or team to assist in planning and implementing plans per the approved Plan of Care.

The specific service delivered must be consistent with the scope of the license held by the professional. Service intensity, frequency, and duration will be determined by individual need. The services may be short-term, intermittent, or long-term, depending on the need. The team developing the plan of support makes determinations for service utilization.

The participant may utilize one or more Professional Services in the same day but not at the same time.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

There is a $2,250 per participant, per Plan of Care year cap for professional services.

Additional services can be prior authorized if the participant reaches the cap before the expiration of the Plan of Care year and the participant's health and safety are at risk.

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
		Massage Therapy		Day Habilitation
		Sex Therapy		
		Acupuncture		
		Art Therapy		
		Music Therapy		
		Dance Therapy		
		Drama Therapy		
		Fitness Trainer		

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Massage Therapy	Chapter 75 of Title 17 of the District of Columbia Municipal Regulations		
Sex Therapy	LCSW		American Association of Sexuality Educators, Counselors and Therapists (AASECT): Credentialing Board
Art Therapy			American Art Therapy Association, Inc: The Art Therapy Credentialing Board
Acupuncture	Chapter 47 of Title 17 of the District of Columbia Municipal Regulations		

Music Therapy		Certification Board for Music Therapists (CBMT), managed by the American Music Therapy Association	
Dance Therapy	Chapter 71 (Dance Therapy) of Subtitle: Health Occupations of Title 17 DCMR (Business, Industry, and Professions).		
Drama Therapy			
Fitness Trainer			
Day Habilitation			Agencies must operate in accordance with DCMR Title 29, Section 945 Day Habilitation Services

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual	DDS	Initially, and annually thereafter
Agency	DDS	Initially, and annually thereafter

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification

Service Title:	**Residential Habilitation**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
O	Service is included in approved waiver. There is no change in service specifications.
X	Service is included in approved waiver. The service specifications have been modified.
O	Service is not included in the approved waiver.
Service Definition (Scope):	

Services are provided in homes for 4-6 participants sharing a home managed by a provider agency. Services are developed in accordance with the needs of the individual and include supports to assist individuals in acquiring, retaining and improving self-care, daily living, adaptive and leisure skills needed to reside successfully in a shared home within the community. Supports include health care and supervision and oversight including 24-hour availability of response staff to meet schedules or unpredictable needs in a way that promotes maximum dignity and independence and nursing. The service provides supervision, safety and security but does not include the time the person is in school or employed. Services are developed in accordance with the participant's Plan of Care.

Payments are not made for room and board, the cost of facility maintenance, upkeep or improvement.

The cost of transportation is included in the residential habilitation rate.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) *(check one or both)*:		Individual. List types:	X	Agency. List the types of agencies:
				Group Home for Mentally Retarded Persons

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Group Home for Mentally Retarded Persons	Ch 35 of Title 22 of the District of Columbia Municipal Regulations- "Licensure of Group Homes for Mentally Retarded Persons"		Provider agreement with Medical Assistance Administration

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Group Home for Mentally Retarded Persons	Department of Health	Initially, annually and as necessary

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Specification

Service Title:	**Respite**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

O	Service is included in approved waiver. There is no change in service specifications.
X	Service is included in approved waiver. The service specifications have been modified.
O	Service is not included in the approved waiver.

Service Definition (Scope):
Services provided to participants unable to care for themselves; furnished on a short-term basis in the participant's home because of the absence or need for relief of those persons normally providing the care. FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the District that is not a private residence. Respite care is in the participant's place of residence. This service is necessary to prevent participants from being institutionalized or sent to an out-of-District program. Respite care will ensure that participants have access to community activities as delineated in the participant's Plan of Care. Community activities, including transportation to and from these activities, are included in the rate for Respite. These activities include ensuring school attendance, or other school activities, or other activities the participant would receive if they were not in respite. These community activities would allow the participant's routine not to be interrupted. Respite is not available to participants receiving Center-Based Respite, Companion Care, Host Home or Residential Habilitation services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limited to 720 hours or 30 days per participant, per Plan of Care year. Services provided cannot exceed those authorized in the Plan of Care. Any request for hours in excess of 720 hours must have DDS approval with proper justification and documentation.

Provider Specifications

Provider Category(s) *(check one or both)*:		Individual. List types:	X	Agency. List the types of agencies:
				Home Health Agency
				Group Homes for Mentally Retarded Persons
				Supported Living Providers

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian (see C-2.e.)

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health Agency	Health-Care and Community Residence Facility Act, Hospice and Home-Care Licensure Act of 1983, effective Feb. 24, 1984 (DC Law 5-48; DC Official Code, § 44-501 et seq), and implementing rules.		

Group Homes for Mentally Retarded Persons	Ch 35 of Title 22 of the District of Columbia Municipal Regulations- "Licensure of Group Homes for Mentally Retarded Persons"		
Supported Living Providers			Provider enrolled to provide services through DDS and has current Medicaid agreement. For individual employees, the following requirements apply: Documentation that each employee is eighteen (18) years of age or older; Documentation that each employee was found acceptable by the participant; Annual documentation from a physician or other official that employee free from communicable disease as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin Test; Record of completion of competency based training in communication with people with intellectual disabilities; Record of completion of competency based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030; A high school diploma or general equivalency development; (GED) certificate from English speaking program or ESL certificate; Record of completion of competency based training in emergency procedures;

			Certification (annual) in cardiopulmonary resuscitation (CPR) and First Aid; Record of completion of DDS approved pre-service and in-service training in DDS policies and procedures; Training needed to address the unique support needs of the participant as detailed in their Plan of Care; and Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13,2002 (D.C. Law 14-98; D.C. Official Code, $5 44-55 1 et seq.).

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Agency	Department of Health: Health Regulation Administration	Initially and annually thereafter or more frequently as needed.
Group Homes for Mentally Retarded Persons	DDS	Initially and annually thereafter
Supported Living Provider	DDS	Initially and annually thereafter

Service Delivery Method

Service Delivery Method *(check each that applies)*:		Participant-directed		Provider managed

Service Specification

Service Title:	**Skilled Nursing Services**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
O	Service is included in approved waiver. There is no change in service specifications.
X	Service is included in approved waiver. The service specifications have been modified.
O	Service is not included in the approved waiver.

Service Definition (Scope):

Services listed in the Plan of Care that are within the scope of the District's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered

nurse, licensed to practice in the District of Columbia. Since Skilled Nursing is an extended State Plan service, waiver participants must exhaust all available skilled nursing visits provided under the District's Medicaid State Plan Services prior to receiving services through this Waiver.

Skilled Nursing services must be included in the participant's Plan of Care, have a physician's order, a physician's letter of medical necessity, an individual nursing service plan, a summary of medical history, and the skilled nursing checklist. The Nurse should submit updates every 60 days if any changes to the individual's needs and/or Physician's orders.

Consulting services include assessments and health related training and education for participants and caregivers. These services may address healthcare needs related to prevention and primary care activities. Consultative services must be performed by a Registered Nurse.

When there is more than one participant in the home receiving skilled nursing services, services may be shared and payment must be coordinated with the service authorization system and each participant's Plan of Care. Nursing consultations are offered on an individualized basis only.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

DDS can approve up to six visits per year of Skilled Nursing services. Skilled Nursing is not available in residential habilitation or supported living.

Provider Specifications

Provider Category(s) *(check one or both)*:		Individual. List types:	X	Agency. List the types of agencies:
				Home Health Agency

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health Agency	Health-Care and Community Residence Facility Act, Hospice and Home-Care Licensure Act of 1983, effective Feb. 24, 1984 (DC Law 5-48; DC Official Code, § 44-501 et seq), and implementing rules.		Nurses are licensed under §302(14) of the District of Columbia Health Occupations Revision Act of 1985, D.C. Law 6-99, D.C. Code §2-3303.2(14) (1988 Repl. Vol.), 33 DCR 729, 732 (February 7, 1986), and Mayor's Order 86-110, 33 DCR 5220 (August 22, 1986)/ Title 17, Chapter 54 (Registered Nursing)

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Agency	Department of Health: Health Regulation Administration	Initially, annually thereafter

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification					
Service Title:	**Speech, Hearing and Language Therapy**				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
O	Service is included in approved waiver. There is no change in service specifications.				
X	Service is included in approved waiver. The service specifications have been modified.				
O	Service is not included in the approved waiver.				
Service Definition (Scope):					
Speech, Hearing and Language Therapy services shall be designed to maximize independence, prevent further disability, and maintain health. These services should be provided in accordance with the participant's Plan of Care. All Speech, Hearing and Language Therapy services should be monitored to determine which services are most appropriate to enhance the individual's well being and to meet the therapeutic goals.					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					

Provider Specifications				
Provider Category(s) *(check one or both)*:	**X**	Individual. List types:		Agency. List the types of agencies:
	Speech Pathologists			

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian (see C-2.e.)

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Speech Pathologists			Accreditation by the American Speech-Language-Hearing Association

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Speech Pathologists	DDS	Initially

Service Delivery Method				
Service Delivery Method *(check each that applies)*:		Participant-directed	**X**	Provider managed

Service Specification

Service Title:	**Supported Employment**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

O	Service is included in approved waiver. There is no change in service specifications.
X	Service is included in approved waiver. The service specifications have been modified.
O	Service is not included in the approved waiver.

Service Definition (Scope):

Supported Employment is competitive work in an integrated work setting, or employment in an integrated work setting in which participants are working toward competitive work, consistent with strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice. Supported Employment is also provided to participants with ongoing support services for whom competitive employment has not traditionally occurred. These are services provided to participants who are not served by the District's Rehabilitation Services and need more intense, long term follow along and usually cannot be competitively employed because supports cannot be successfully faded.

Supported Employment is:

1. Vocational assessments: All vocational assessments, regardless of the participant's vocational placement, are conducted by supported employment providers;
2. Individual placement: A supported employment placement strategy in which an employment specialist (job coach) places a participant into competitive employment through a job discovery process, provides training and support, and then gradually reduces time and assistance at the worksite;
3. Enclave: An employment situation in competitive employment in which a group of eight or fewer participants with disabilities are working at a particular work setting. The participants may be disbursed throughout the company and among workers without disabilities or congregated as a group in one part of the business;
4. Mobile Work Crew: A group of eight or fewer participants who perform work in a variety of locations under the supervision of a permanent employment specialist (job coach/supervisor);
5. Development and on-going support for micro-enterprises owned and operated by the participant. This assistance consists of: (a) assisting the participant to identify potential business opportunities; (b) assisting the participant in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business; (c) identification of the supports that are necessary in order for the participant to operate the business; and, (d) ongoing assistance, counseling and guidance once the business has been launched.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for vocational training that is not directly related to a participant's supported employment program.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Exclusions:

1. Day Habilitation, Pre-Vocational Services and In-Home Supports shall not be used in conjunction or simultaneously with this service.
2. When Supported Employment services are provided at a work site in which persons without disabilities are employees, payment will be made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities, and will not include payment for the supervisory

activities rendered as a normal part of the business setting.
3. Services are not available to individuals who are eligible to participate in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Individuals with Disabilities Education Act, 20 U.S.C. 1401(16) and (71).

Service Limits:
1. One-to-One intensive services shall not exceed 1,280 1/4 hour units per Plan of Care year.
2. Services shall be limited to no more than eight hours a day, five days a week, for eight weeks.
3. Follow along services shall not exceed 24 days per Plan of Care year.
4. Mobile Crew/Enclave services shall not exceed 8,320 1/4 hour units of service per Plan of Care year, without additional documentation. This is eight hours per day, five days per week.
5. Time spent in transportation to and from the program shall not be included in the total amount of services provided per day.

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Supported Employment Provider

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Supported Employment Provider	Chapter 9 of Title 29 of the District of Columbia Municipal Regulations		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Supported Employment Provider	DDS	Initially, annually, and as necessary

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Specification

Service Title:	**Supported Living**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

O	Service is included in approved waiver. There is no change in service specifications.
O	Service is included in approved waiver. The service specifications have been modified.
X	Service is not included in the approved waiver.

Service Definition (Scope):

This service is designed to provide support to participants who have limited informal supports and have an assessed need for assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the participant to reside in a non-institutional setting. This service is provided by an agency in a home serving one to three participants that is owned or leased and operated by the agency. Payment for Supported Living is not made for cost of room and board, the cost of home maintenance, upkeep and improvement, modifications or adaptations to a home, or to meet the requirements of the applicable life safety code. Payment for Supported Living does not include payments made, directly or indirectly, to members of the participant's immediate family.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services are not reimbursed when the participant is receiving Center-Based Respite or Respite.

A 24-hour setting for a single participant is only possible when the participant is a danger to others, as determined by psychological assessment and/or court order. The psychological assessment must be updated on an annual basis to determine the continued necessity for this single 24-hour placement.

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Supported Living Agencies

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian (see C-2.e.)

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Supported Living Agencies			Provider enrolled to provide services through DDS and has current Medicaid agreement. For individual employees, the following requirements apply: Documentation that each employee is eighteen (18) years of age or older; Documentation that each employee was found acceptable by the participant; Annual documentation from a physician or other official that employee free from communicable disease as confirmed by an

			annual purified protein derivative of tuberculin (PPD) Skin Test; Record of completion of competency based training in communication with people with intellectual disabilities; Record of completion of competency based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030; A high school diploma or general equivalency development; (GED) certificate from English speaking program or ESL certificate; Record of completion of competency based training in emergency procedures; Certification (annual) in cardiopulmonary resuscitation (CPR) and First Aid; Record of completion of DDS approved pre-service and in-service training in DDS policies and procedures; Training needed to address the unique support needs of the participant as detailed in their Plan of Care; and Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13,2002 (D.C. Law 14-98; D.C. Official Code, $5 44-55 1 et seq.).

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Supported Living Agencies	DDS	Initially, and annually thereafter

Service Delivery Method				
Service Delivery Method *(check each that applies)*:		Participant-directed	X	Provider managed

Service Specification	
Service Title:	**Transportation –Community Access**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
O	Service is included in approved waiver. There is no change in service specifications.
X	Service is included in approved waiver. The service specifications have been modified.
O	Service is not included in the approved waiver.

Service Definition (Scope):

Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, as specified by Plan of Care.

This service shall not replace:

1. Transportation services to medically necessary services under the State Plan;
2. Transportation services provided as a means to get to and from school; and
3. Transportation provided per waiver services definitions of center-based respite, day habilitation services, prevocational habilitation, supported employment and shared living.

Transportation services under the waiver shall be offered in accordance with and documented in the participant's Plan of Care. The participant must be present to receive this service. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized. Whenever possible, public transportation or the most cost-effective method of transport will be utilized.

This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State Plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The cap on this service is $2,400 per year. Proposed expenditures above this cap must be reviewed and approved by DDS.

Transportation can be billed as a maximum of two one-way trips per service day regardless of the number of places the participant receives the service or billed as one round-trip service to one location.

Provider Specifications				
Provider Category(s) *(check one or both)*:		Individual. List types:	X	Agency. List the types of agencies:
				Transportation Provider
Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	X	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Transportation Provider			The following standards apply: 1. The vehicle in which transportation is provided must have valid license plates, and at a minimum, appropriate insurance as required by law and certification by the Washington Metropolitan Area Transit Commission (WMATC). The vehicle must pass an inspection performed by a certified inspection station every six months. A copy of the Certificate of Inspection must be submitted to the Medical Assistance Administration (MAA). 2. The vehicle will be maintained in a safe, working order. 3. The vehicle shall be constructed for the transportation of individuals. All seats shall be fastened to the body of the vehicle and the individual(s) must be properly seated when the vehicle is in operation. The vehicle must have operational seat belts installed and be operational for safe passenger utilization. During transport, individuals must be securely fashioned in age and weight appropriate restraints, as required by law. 4. Individuals with special mobility needs shall be transported in a vehicle adapted to those needs as required to facilitate adequate safety and access to service. 5. If the vehicle is used to transport individuals in wheelchairs, it shall also be equipped with floor-mounted seat belts and wheelchair lock-downs for each wheelchair that it transports. 6. Persons providing transportation must be a minimum of eighteen (18) years of age, and possess and maintain a valid commercial driver license, certified to perform CPR

			and First Aid and pass an annual drug test.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Transportation Provider	DDS	Initially, and annually thereafter

Service Delivery Method *(check each that applies)*:		Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	Transportation –Vocational

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

O	Service is included in approved waiver. There is no change in service specifications.
X	Service is included in approved waiver. The service specifications have been modified.
O	Service is not included in the approved waiver.

Service Definition (Scope):

Service offered in order to enable waiver participants to gain access to vocational services, activities and resources, as specified by the Plan of Care.

This service shall not replace:
1. Transportation services to medically necessary services under the State Plan; and
2. Transportation services provided as a means to get to and from school.

Transportation services under the waiver shall be offered in accordance with and documented in the participant's Plan of Care. The participant must be present to receive this service. Whenever possible, family, neighbors, friends or community agencies which can provide this service without charge will be utilized. Whenever possible, public transportation or the most cost-effective method of transport will be utilized.

Transportation services are meant to provide maximum flexibility to the participant to choose the mode of transportation they wish to use to reach the vocational site. If vocational providers are providing the transportation, they may bill for reimbursement. If the participant is using other modes of public transportation (e.g., bus, taxi), then the participant must submit receipts to a waiver-enrolled provider in order to get reimbursed. MAA and DDS: **Is this permitted?**

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Transportation can be billed as a maximum of two one-way trips per service day for a maximum of 264 days and 728 service units regardless of the number of places the person receives the service.

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Transportation Provider

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	X	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Transportation Provider			The following standards apply: 1. The vehicle in which transportation is provided must have valid license plates, and at a minimum, appropriate insurance as required by law and certification by the Washington Metropolitan Area Transit Commission (WMATC). The vehicle must pass an inspection performed by a certified inspection station every six months. A copy of the Certificate of Inspection must be submitted to the Medical Assistance Administration (MAA). 2. The vehicle will be maintained in a safe, working order. 3. The vehicle shall be constructed for the transportation of individuals. All seats shall be fastened to the body of the vehicle and the individual(s) must be properly seated when the vehicle is in operation. The vehicle must have operational seat belts installed and be operational for safe passenger utilization. During transport, individuals must be securely fashioned in age and weight appropriate restraints, as required by law. 4. Individuals with special mobility needs shall be transported in a vehicle adapted to those needs as required to facilitate adequate

			safety and access to service. 5. If the vehicle is used to transport individuals in wheelchairs, it shall also be equipped with floor-mounted seat belts and wheelchair lock-downs for each wheelchair that it transports. 6. Persons providing transportation must be a minimum of eighteen (18) years of age, and possess and maintain a valid commercial driver license, certified to perform CPR and First Aid and pass an annual drug test.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Transportation Provider	DDS	Initially, and annually thereafter

Service Specification	
Service Title:	**Vehicle Modifications**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
O	Service is included in approved waiver. There is no change in service specifications.
O	Service is included in approved waiver. The service specifications have been modified.
X	Service is not included in the approved waiver.

Service Definition (Scope):

Vehicle modifications are designed to help the participant function with greater independence. Such adaptations to the vehicle may include a lift, or other adaptations to make the vehicle accessible to the participant, or for the participant to drive. Excluded are those adaptations, which are of general utility, or for maintenance of the vehicle, or for repairs to adaptations. Car seats are not considered as a vehicle adaptation.

All providers must meet any District for licensure or certification, as well as the person performing the service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A cap of $10,000 for a five year period for this service per participant. On a case by case basis, with supporting documentation and based on need, a participant may be able to exceed this cap with the approval of DDS and

with the limits beyond the capped prior authorized. No more than two vehicles modified in a five year period; exceptions may be approved by DDS.

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Individual Proprietor		Business Entity	

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual Proprietor	Chapter 11, Subtitle IV of Title 50 of the District of Columbia Municipal Regulations		Individual Proprietors of vehicle adaptations shall have a current license, certification, or registration with the District of Columbia as appropriate for the services being purchased. The Proprietor shall also possess a current license to do business issued in accordance with the laws of the District of Columbia. Proprietors shall demonstrate knowledge in meeting applicable standards of installation, repair, and maintenance of vehicle adaptations and shall also be authorized by the manufacturer to install, repair, and maintain such systems where possible.
Business Entity	Chapter 11, Subtitle IV of Title 50 of the District of Columbia Municipal Regulations		Business Entity of vehicle adaptations shall have a current license, certification, or registration with the District of Columbia as appropriate for the services being purchased. The Business Entity shall also possess a current license to do business issued in accordance with the laws of the District of Columbia. Business Entities shall demonstrate knowledge in meeting applicable standards of installation, repair, and maintenance of vehicle adaptations and shall also be authorized by the manufacturer to install, repair, and maintain such systems where possible.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual Proprietor	DDS	Initially, and annually thereafter
Business Entity	**DDS**	Initially, and annually thereafter

Service Delivery Method *(check each that applies)*:		Participant-directed as specified in Appendix E	**X**	Provider managed

Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies).*

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; and, (f) how participants are notified of the amount of the limit.

☐	**Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *Furnish the information specified above.*
☐	**Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above.*
☐	**Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above.*
☐	**Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*
X	**Not applicable.** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Individual Support Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(check each that applies)*:

☐	Registered nurse, licensed to practice in the State
☐	Licensed practical or vocational nurse, acting within the scope of practice under State law
☐	Licensed physician (M.D. or D.O)
☐	Case Manager (qualifications specified in Appendix C-3)
X	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
	Bachelor's Degree in a human service-related field including but not limited to Psychology, Education, Counseling, Rehabilitation Counseling or General Studies with a major concentration in a human services-related field from an accredited institution and one year of full-time paid post-degree experience in a human service-related field providing direct participant services or case management; thirty hours of graduate level course credit in the human service related field may be substituted for the year of required paid experience or a licensed registered nurse and one year of full-time paid experience as a registered nurse in public health or a human service-related field providing direct participant services or case management; thirty hours of graduate level course credit in the human service related field may be substituted for the year of required paid experience or a Bachelor's or Master's degree in Social Work from a social work program accredited by the Council on Social Work Education. Experience gained as part of the educational process, i.e., a field placement, internship or practicum, is part of the qualifying education and may not be counted toward the post-educational experience. Experience gained while employed in a position in which minimum qualifications were not initially met cannot be counted toward the required experience. Experience as a teacher does not qualify as direct services.
☐	Social Worker. *Specify qualifications:*
☐	Other (*specify the individuals and their qualifications):*

b. Service Plan Development Safeguards. *Select one:*

X	Entities and/or individuals that have responsibility for service plan development *may not provide* other direct waiver services to the participant.

O	Entities and/or individuals that have responsibility for service plan development *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The initial Plan of Care meeting is developed within 30 days of determination of eligibility. Prior to the completion of the initial Plan, the Case Manager arranges for any emergency service such as residential placement, medical, psychiatric or behavioral intervention.

Prior to the annual Plan of Care meeting, the Case Manager meets with the participant (and their family/legal representatives, as appropriate). The meeting is conducted face-to-face in the participant's place of choice or the offices of the Department of Disability Services, depending on which is more convenient. During this visit, the participant chooses who will be part of their planning process as their Team. The Case Manager assists the participant in contacting the team members with the date, location and time of the meeting. Additionally, this meeting is used to assist the participant in reviewing their progress in meeting the previous year's goals. The participant's preferences, needs, goals and desires for the next year are discussed. Finally, the Case Manager is responsible for informing the participant of their freedom of choice of providers during this meeting (and more frequently as needed, should a situation arise mid-cycle during the Plan of Care year which requires consideration of a provider change). The Case Manager has the responsibility of ensuring that this information drives the development of the Plan of Care.

A standardized person-centered planning format is used throughout the Plan of Care development process. The Plan of Care is developed by the Team, which includes the participant, their family/legal representatives (as appropriate), the Case Manager and others invited by the participant. These Team members know and work with the participant and their active involvement is necessary to achieve the outcomes desired by the participant.

d. Service Plan Development Process In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

DC Code Title 2- Section 137 describes the requirements for the Plan of Care process.

The Plan of Care process assures that participants have access to quality services and supports that foster independence, learning and growth; choices in everyday life; meaningful relationships with family, friends and neighbors, presence and participation in the fabric of community life; dignity and respect; positive approaches aimed at skill development; and health and safety. The Plan of Care process is driven by the participant's vision, goals and needs with overall management and facilitation provided by the Case Manager. The District's procedures to address the terms and conditions of the Plan of Care section of the waiver application are as follows:

a. SERVICE PLAN DEVELOPMENT AND TIMING

Upon being determined eligible for waiver services, the participant's assigned Case Manager explains all available services in the Waiver during the initial contact so that the participant and their family/legal representatives can make informed choices. The participant is also informed of all procedural safeguards, their rights and responsibilities, how to request a change of providers, and the District's grievance and complaint procedures. This initial Case Manager contact with the participant occurs within 30 days of being determined eligible.

The Plan of Care is developed through a collaborative support team process involving the participant, family, friends or other support systems, legal representatives, the Case Manager, appropriate professionals/service providers, and others who the participant chooses to be involved. The Plan must be completed within 30 calendar days of the participant's date of eligibility.

The Case Manager facilitates the Plan of Care meeting. The Case Manager is ultimately responsible for the development and monitoring of the Plan of Care.

Following completion of the annual Plan of Care meeting and no later than 30 days of the meeting, the Case Manager Supervisor, employed by DDS, reviews and approves the Plan of Care. The Supervisor is responsible for ensuring that the waiver services are clearly delineated and justified, based upon the needs identified in the Plan of Care and its accompanying assessments. The Plan of Care is implemented within 30 days of the Plan of Care meeting.

Annually, the entire team meets to review and revise the Plan for the upcoming service year. The annual date of the Plan of Care does not change, even if there has been a recent meeting to revise

the Plan.

b. ASSESSMENTS

Personal interviews are conducted with each participant during the Plan of Care development process. The initial assessment processes, using standardized assessment tools must begin within 30 days of notification of the initiation of services. The Health Risk Screening Tool is used to assist in predicting the Medicaid waiver program's ability to assure the individual's health and safety.

During the assessment process, the Case Manager collects the following information:

1. The personal outcomes envisioned, defined and prioritized by the participant;
2. Medical/physical information and documentation; psycho- social/behavioral information and documentation;
3. Developmental/intellectual information and documentation;
4. Socialization/recreational information and documentation, including relationships that are important to the participant and the social environment of the participant;
5. Patterns of the participant's everyday life;
6. Identification of informal supports available to the participant;
7. Information and documentation on financial resources;
8. Educational/vocational information and documentation;
9. Information on the current status of housing and the physical environment;
10. Information about previously successful and unsuccessful strategies to achieve the participant's desired personal outcomes;
11. Safeguards for protection from harm; and
12. Any other information relevant to understanding the supports and services needed by the participant to achieve the desired personal outcomes.

A reassessment may be conducted at any time, particularly with a significant change in the participant's status. The assessment process is ongoing, and designed to reflect changes in the participant's life, individual needs, and changing personal outcomes, including strengths, needs, preferences, abilities and resources.

c. HOW PARTICIPANTS ARE INFORMED OF AVAILABLE SERVICES

Participants and their legal representatives are informed of available waiver services during the initial contact with the Case Manager. Participants are then made aware of waiver services available during the Plan of Care development process, and more frequently as needed should circumstances arise that prompt an interest in changing providers.

d. INCORPORATION OF PARTICIPANT GOALS/NEEDS/PREFERENCES IN PLAN

The Plan of Care must incorporate the following required components:

1. The participant's prioritized personal outcomes, and specific strategies to achieve or maintain the desired personal outcomes, focusing first on informal and community supports and, if needed, paid

formal services;

2. An action plan which will lead to the implementation of strategies to achieve the desired personal outcomes, including action steps, review dates and individuals who will be responsible for specific steps, ensuring that the steps which are incorporated empower and help the participant to develop independence, growth, and self-management;

3. Target dates for the achievement/maintenance of personal outcomes;

4. Identification of the preferred formal and informal service providers and specification of the service arrangements;

5. Identification of individuals who will assist the Case Manager in planning, building/implementing supports, or direct services; and

6. Signatures on the Plan of Care from the participant and all Team members present indicating their agreement with the Plan of Care.

It is the requirement of this information and its inclusion in the Plan of Care that ensures the participant's goals, needs, including health care needs and preferences are addressed.

d. COORDINATION OF WAIVER SERVICES

Waiver and other identified services on the Plan of Care are coordinated through the Case Manager. Case Managers are required to make monthly contact with each participant, and make a face-to-face visit with the participant on a monthly basis. During eight of these monthly contacts, Case Managers review information on the Plan of Care, track progress on identified goals and time lines, and get updated information on the progress of informal/unpaid supports identified in the Plan of Care; a Case Management Visit Monitoring Tool is completed at each of these eight meetings. Information from the Tool is entered into the DDS MCIS system and is reviewed by the Case Manager Supervisor. Any concerns are addressed by the Supervisor.

The participant and their legal representatives may contact the Case Manager at any time for assistance. Formal monthly contacts offer an opportunity for the participant to request a Team meeting to make formal revisions to the Plan of Care, and for the Case Manager to request a reassessment or a new assessment.

e. ASSIGNMENT OF RESPONSIBILITIES TO IMPLEMENT AND MONITOR PLAN

Each goal identified on the Plan of Care has a time frame for accomplishment. The Case Manager is responsible for monitoring the progress of goals to ensure that they are completed or revisions are made as necessary when identified goals change, or cannot be accomplished within the identified time frames.

During the development of the Plan of Care, Team members volunteer or are asked to take on roles and responsibilities to facilitate linkage of the participant to the identified services and supports that are outside of the Medicaid-funded services. During monthly contacts with the participant and their legal representatives, the Case Manager receives information on the progress of these assignments and their success in assisting the participant to have a high quality of life.

Every six months, or more frequently as needed, the Case Manager, the participant, the service provider(s) and others the participant chooses to be present, review the Plan of Care to determine if the goals identified on the Plan are being achieved, the participant's needs, including health and

safety are being addressed, and to make any adjustments or changes necessary to the Plan.

g. HOW AND WHEN PLAN IS UPDATED

The Plan of Care must be revised annually or as necessary to meet the needs of the participant. The Case Manager is tasked with arranging for any needed assessments and contacting the participant to arrange for the scheduling and location of the meeting. The Case Manager also contacts the participant's service providers to inform them of the meeting. The Plan of Care meeting is always completed before the anniversary date of the current Plan of Care. The Case Manager is solely responsible for ensuring that the Plan of Care is conducted in accordance with DDS requirements and is consistent with best practice in the field of developmental disabilities.

Mid-Plan of Care cycle changes that require Plan of Care revisions are coordinated by the case manager. Documentation for the Plan of Care revision is completed by the case manager and submitted to the Case Manager Supervisor for review and approval. The Supervisor has two business days to review and approve the Plan of Care or return it to the case manager for additional information.

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

DDS will be implementing a risk assessment process that will conform to CMS requirements. The following is the description of this process:

The Plan of Care Team, as part of their preparation for the Plan of Care meeting, completes an assessment that identifies potential areas in which the participant's safety is at risk, including physical, emotional, medical, financial and legal risks, as well as risks to community participation; the frequency and degree of potential harm to the participant and/or others; and why, when, where and how the risk to safety may occur. This includes identification of the participant's understanding of the risk and their skills at addressing the risk. The assessment process includes interviews with the participant and their legal representatives. The Case Manager conducts a review of any critical incidents during the preceding year.

During the planning process, the Team members discuss possible strategies to mitigate potential risks that have been identified. Development of strategies to mitigate risks shall take into account the needs and preferences of the participant. The approach that will be utilized to mitigate each specific risk may be incorporated into the Plan of Care.

The emergency back-up plan is a core component of the Plan of Care format and is completed at the time of the planning meeting. All enrolled providers of waiver services must possess the capacity to provide the support and services required by the participant in order to insure the participant's health and safety as determined by the Team and detailed in the Plan of Care. When paid supports are scheduled to be provided by an enrolled provider of waiver services, that provider is responsible for providing all necessary staff to fulfill the health and safety needs of the participant, including times when scheduled direct support staff is absent, unavailable or unable to work for any reason.

The identified enrolled provider of waiver services cannot use the participant's informal support system as a means of meeting the participant's back-up plan unless the participant, with assistance

from their Team, has agreed to do so. This agreement must be documented in the Plan of Care.

The Case Manager assists the participant and the Team members to identify individuals who are willing and able to provide a back-up system during times when paid supports are not scheduled on the participant's Plan of Care.

Back-up plans are updated no less than annually through the Plan of Care process to assure information is kept current and applicable to the participant's needs at all times.

The identified enrolled provider of waiver services must have in place policies and procedures that outline the protocols the agency has established to assure that back-up direct support staff are readily available, lines of communication and chain-of-command have been established, and procedures are in place for dissemination of the back-up plan information to participants, their legal representatives, and Case Manager.

Protocols outlining how and when the direct support staff are to be trained in the care and supports needed by the participant must also be included. This training must occur prior to any direct service worker being solely responsible for the support of the participant.

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The participant and their legal representatives are informed of the services available under the waiver during the Case Manager's initial contact with the participant. Part of this contact involves a discussion of Freedom of Choice of qualified waiver providers and the availability of services. The Case Manager and the participant and their legal representatives also discuss the role of the Case Manager and determine the supports the participant requires from Case Management.

The Case Manager provides the participant with a list of all qualified Medicaid providers and the specific waiver services they offer. The participant and their legal representative are encouraged by the Case Manager to interview or visit each provider agency they are interested in, in order to make informed choices. The Case Manager is available to assist the participant in contacting and interviewing potential providers. The Case Manager also has the responsibility of assisting the participant when they wish to change providers.

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Within 30 days of finalizing the Plan of Care, the Plan of Care is distributed to the participant, their legal representative as appropriate, and all other relevant parties. Information from the Plan of Care is entered into the MCIS database. The DDS Waiver Unit forwards copies of all Plans of Care to MAA. A random review of 10% of the Plans of Care is conducted by MAA, which includes a documentation review as well as a small sample of on-site reviews.

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. *Specify the minimum schedule for the review and update of the service plan:*

O	Every three months or more frequently when necessary
O	Every six months or more frequently when necessary
X	Every twelve months or more frequently when necessary

O	Other schedule (*specify*):

i. **Maintenance of Service Plan Forms**. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies)*:

☐	Medicaid agency
X	Operating agency
☐	Case manager
☐	Other (*specify):*

Appendix D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Case Manager is responsible for monitoring the implementation of the Plan of Care and the effectiveness of the Plan in meeting the participant's needs, preferences, and health and welfare. The Case Manager assesses the effectiveness of the Plan of Care eight times per year and more frequently as needed through contact with the participant as well as a review of documentation submitted by providers related to Plan implementation and progress. Monthly face-to-face meetings between the participant and the Case Manager provide an in-depth opportunity for the Case Manager to assess the participant's well-being and the effectiveness of the services provided through the Plan of Care. During these contacts the Case Manager checks to make sure that:

1. There is access to waiver and non-waiver services identified in the Plan, including access to health services;
2. The strategies to meet the participant's personal goals are being implemented and the effectiveness of the strategies;
3. The services outlined on the Plan are meeting the needs of the participant;
4. The participant is satisfied with the service providers they have chosen;
5. Services are being furnished in accordance with the Plan;
6. The participant's health and welfare needs are being met; and
7. Back-up plans, if utilized, are effective and persons identified as responsible for back-up plans are still active in the participant's life.

If at any time the Case Manager believes the participant is at risk, the Case Manager is charged with taking all immediate steps necessary to protect the participant.

If the Case Manager determines that services are not effectively addressing the needs or preferences of the participant, the Case Manager is charged with convening the Team to make necessary revisions to the Plan of Care. If it is determined that the provider is not implementing the Plan of Care as required or does not meet contractual responsibilities or DDS policies, the Case Manager consults with the provider to secure a commitment from the provider for the necessary change. If the service deficiency is not resolved within the agreed time, the Case Manager informs the Case Manager Supervisor who in turn intervenes with the provider. Continued lack of compliance results in an administrative inquiry by DDS, which may lead to sanctions including but not limited to termination of the agreement to serve the participant.

b. Monitoring Safeguards. *Select one:*

X	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.
O	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:

Appendix E: Participant Direction of Services

[NOTE: *Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.*]

Applicability *(select one)*:

O	**Yes.** This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
X	**No.** This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction. Indicate whether Independence Plus designation is requested (select one):

O	**Yes.** The State requests that this waiver be considered for Independence Plus designation.
O	**No.** Independence Plus designation is not requested.

Appendix E-1: Overview

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

O	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
O	**Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
O	**Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

☐	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
☐	Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
☐	The participant direction opportunities are available to persons in the following other living arrangements *(specify)*:

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one):*

O	Waiver is designed to support only individuals who want to direct their services.
O	The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
O	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. *Specify the criteria*:

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one)*:

O	The State does not provide for the direction of waiver services by a representative.	
O	The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: *(check each that applies)*:	
	☐	Waiver services may be directed by a legal representative of the participant.
	☐	Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-3. *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Waiver Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

○	**Yes**. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i)*. Specify whether governmental and/or private entities furnish these services. *Check each that applies:*
	☐ Governmental entities
	☐ Private entities
○	**No**. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i.*

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○	FMS are covered as the waiver service entitled as specified in Appendix C-3.	
○	FMS are provided as an administrative activity. *Provide the following information:*	
	i.	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:
	ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:
	iii.	**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*
		Supports furnished when the participant is the employer of direct support workers:
		☐ Assist participant in verifying support worker citizenship status
		☐ Collect and process timesheets of support workers
		☐ Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

		☐ Other *(specify):*
		Supports furnished when the participant exercises budget authority:
		☐ Maintain a separate account for each participant's participant-directed budget
		☐ Track and report participant funds, disbursements and the balance of participant funds
		☐ Process and pay invoices for goods and services approved in the service plan
		☐ Provide participant with periodic reports of expenditures and the status of the participant-directed budget
		☐ Other services and supports *(specify)*:
		Additional functions/activities:
		☐ Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
		☐ Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
		☐ Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
		☐ Other *(specify):*
	iv.	**Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*

☐	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled:
☐	**Administrative Activity**. Information and assistance in support of participant direction are furnished as an administrative activity. *Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

k. Independent Advocacy *(select one).*

○	**Yes.** Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy:*
○	**No.** Arrangements have not been made for independent advocacy.

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		
Year 2		

Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

Appendix E-2: Opportunities for Participant-Direction

a. Participant – Employer Authority *(Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b)*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Check each that applies:*

☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. *Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff; the standards and qualifications the State requires of such entities and the safeguards in place to ensure that individuals maintain control and oversight of the employee.:*
☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Check the decision making authorities that participants exercise*:

☐	Recruit staff
☐	Refer staff to agency for hiring (co-employer)
☐	Select staff from worker registry
☐	Hire staff (common law employer)
☐	Verify staff qualifications
☐	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
☐	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
☐	Determine staff duties consistent with the service specifications in Appendix C-3.
☐	Determine staff wages and benefits subject to applicable State limits
☐	Schedule staff
☐	Orient and instruct-staff in duties
☐	Supervise staff
☐	Evaluate staff performance
☐	Verify time worked by staff and approve time sheets
☐	Discharge staff (common law employer)
☐	Discharge staff from providing services (co-employer)

☐	Other *(specify)*:

b. Participant – Budget Authority *(Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b)*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply*:

☐	Reallocate funds among services included in the budget
☐	Determine the amount paid for services within the State's established limits
☐	Substitute service providers
☐	Schedule the provision of services
☐	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
☐	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
☐	Identify service providers and refer for provider enrollment
☐	Authorize payment for waiver goods and services
☐	Review and approve provider invoices for services rendered
☐	Other *(specify)*:

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

iv. Participant Exercise of Budget Flexibility. *Select one:*

O	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
O	Modifications to the participant-directed budget must be preceded by a change in the service plan.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Any individual seeking DDS HCBS Medicaid Waiver services is offered opportunities to request a fair hearing. In addition, each waiver participant is informed of their right to choose the provider of their choice for service at the time of the Plan of Care meeting. Should a participant be denied a service or an applicant be denied admittance to the DDS Waiver, they have the right to request a fair hearing.

Official introduction to waiver resources is provided by the DDS Intake Unit; this introduction also includes information on the right to a fair hearing, and information on how to request a fair hearing. Applicants interested in the DDS waiver receive a DDS waiver brochure, DDS provider directory and instructions on how to access the DDS waiver Program. At that time, information regarding the fair hearing process is also provided, including grounds for appeal such as denial of a service and disputes that are not reconciled through dialogue with the DDS waiver provider or with DDS.

In accordance with the District municipal regulations, the DOH Office on Administrative Hearings ultimately grants individuals and/ or providers the opportunity to receive a fair hearing based on a request. Each participant is given the opportunity to request a fair hearing in writing and is given information on the location to send the fair hearing request. The following instances are described when notices must be made to an individual of a denial of service: "HCBS and institutional services are choice services selected by the participant. The District maintains no responsibility for the participant's choice; as clarified in the Beneficiary Freedom of Choice form signed by each potential service recipient."

When an applicant is informed of his ineligibility for Medicaid and thus the HCBS (DDS) Waiver, the Income Maintenance Administration sends a denial letter to the applicant. The Case Manager contacts the applicant and discusses the reasons for the denial with the potential service recipient. If the applicant is denied a Level of Care by the DDS Waiver Unit, a denial letter which includes the information on how to access the fair hearing process is sent to the applicant by DDS.

When a participant is discharged or terminated for service, he must be given 30 days written notice by the agency. The case manager is also responsible for assisting the participant in pursuing any necessary action, if necessary.

A participant is informed that services will continue during the period while the participant's appeal is under consideration. If the applicant is not eligible for Medicaid, services will not have started. If the applicant is determined eligible based on level of care, then services have not started and the appeal process

may be initiated by the applicant. If a participant's services have been terminated and/or suspended, the provider agency continues services while the appeal is processed and until the outcome of the hearing. If needed alternative arrangements are made for continuation of services. Notification will be made to the participant by the provider agency.

All notices of fair hearings and requests are maintained in the District's Office of Fair Hearings and the Office of the Attorney General for the Medical Assistance Administration (Medicaid).

An Appellants' Bill of Rights and Request for a Hearing Case form is available for review in the DC Medicaid Office.

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one*:

O	**Yes**. The State operates an additional dispute resolution process *(complete Item b)*
X	**No**. This Appendix does not apply (*do not complete Item b)*

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

X	**Yes.** The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver *(complete the remaining items).*
O	**No.** This Appendix does not apply (*do not complete the remaining items*)

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

DDS – Office of Human Rights and the Human Rights Committee, and the Office of the DDS Administrator.

Department of Health/MAA

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

MRDDA (DDS) policy 8.1-Human Rights- affirms individual rights for those supported by DDS, its subcontractors, staff and service providers. Each Provider Agency is required to maintain a Human Rights Committee to review Behavior Support Plans using restrictive procedures; use of unplanned restrictive procedures; and, serious reportable incidents. DDS maintains a Human Rights Advisory Committee charged with oversight and advice to include but not be limited to: Any matter that can not be resolved at the Provider Human Rights Committee level; Human Rights violations; Appeals of Provider Human Rights Committee decisions and/or a grievance against a Provider Human Rights Committee; Nursing Home placements or placements to more restrictive settings; and, the Committee shall review all pertinent data and analysis and make appropriate recommendations regarding human rights.

DDS maintains a process for addressing all DDS Waiver related complaints. The participant is informed that filing a grievance or complaint is not a prerequisite or substitute for a fair hearing. The participant has the right to utilize the complaints process by writing a letter to the DDS Director, requesting a Fair Hearing through MAA or taking additional action through litigation. The participant is not bound by the DDS or MAA complaint process from taking legal action at any time. The DDS complaint process is coordinated by the DDS Human Rights Office. A complainant need not go through the grievance process prior to requesting a fair hearing.

The grievance process is handled on two levels, verbally and in writing. Complaints, both verbal and in writing, are received by the DDS Human Rights Office and or may be reported directly to MAA. Each complaint or grievance receives personal attention, as warranted. The DOH Health Regulation Administration receives copies of all provider-related complaints tied to licensed facilities from DDS and MAA and takes action, as needed. For non-licensed facilities, the DDS Office of Incident Management and Enforcement manages all complaints. Procedures are as follows:

The following information is collected at the time a complaint is received:

- Complainant information (name, address, telephone number, etc.);
- Individuals involved and affected, witness, and accusers;
- Allegation categories (abuse, neglect, lack of or inconsistency in the provision of services,

failure to provide appropriate care or medical intervention, etc);

- Narrative/specifics of allegation/incident;
- If the complainant believes that this is an isolated event or a systematic problem and why and how the complainant believes the incident occurred;
- Date and time of allegation;
- Date/time/frequency of incidence occurrence;
- Location of the incident;
- Courses of action initiated; and
- Complainant's expectation/desire for resolution, if any.

DDS reviews collected data and investigates allegations. In the instance of a provider-related complaint, DDS requests a written account from the provider within 14 calendar days of notice. Information included in the account should be the occurrence, list of involved participants, any witnesses, physical injuries (as indicated), hospital injuries (as indicated), challenges identified and resolution of identified challenges. The Provider must also identify deficiencies and a corrective action plan. Participants are informed of the corrective action plans and their right to Fair Hearing, if wanted. The following District laws govern these policies and procedures: D.C. Municipal Regulation (DCMR) Incidents and Complaints Chapter 42, Title 29; and Home Care Agencies Complaint Process, Chapter 39, Title 22. DDS will prepare rules for the DDS Waiver prior to the requested start date of this waiver.

On admission to the DDS Waiver program, the DDS Bill of Rights and Responsibilities Form (Revised) is given to participants. The form addresses the ability of participants to file complaints and assures that no reprisal shall occur by any party if a complaint is filed. The form is signed by the participant and reflects language that clearly states that the participant shall not be penalized or suffer any reprisals as a result of filing a grievance.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The District of Columbia uses a three-level approach to reporting and investigating incidents involving participants served by DDS. Level 1 includes serious reportable incidents involving death, abuse, neglect, theft of the consumer's personal property, or serious physical injury. Level 2 includes serious reportable incidents involving serious medication error, improper use of restraints, emergency inpatient hospitalization, suicide attempt or threat, missing person, or 911 calls for law enforcement personnel, emergency medical assistance or fire. Level 3 includes all other reportable incidents (not included in Levels 1 or 2) that are not considered serious or significant enough to require an independent investigation by the DDS, such as when a participant is taken to the hospital by the provider staff for a physical injury or a cut or abrasion not requiring stitches, an automobile accident or an accidental detachment of a toe nail.

The policy and operating procedures, which include extensive definitions for each incident type and the reporting requirements, are set forth in MRDDA Policy No. 6.2 dated September 30, 2006, and the Operational Procedures for the Office of Investigations and Compliance, which is now known as the Incident Management and Enforcement Unit (IMEU). According to the incident management policy, employees, sub-contractors, consultants, volunteers or interns of a provider or governmental agency are required to make an oral report immediately when a serious reportable incident (*i.e.* Level 1 and 2) or reportable incident (*i.e.* Level 3) is witnessed, discovered or becomes known.

All incidents must be recorded on the DDS Incident Report form, which must be maintained by the provider for monthly tracking and trending, and must be submitted to DDS, the Quality Trust for Individuals with Disabilities, Inc. (Quality Trust), the Department of Health's Health Regulation Administration (HRA) and Medical Assistance Administration (MAA), and the *Evans* Court Monitor upon request. The provider also is required to document the incident in the DDS Consumer Information System (MCIS) within 24 hours of the incident. For serious reportable incidents, providers are required to forward a copy to the District's Office of the Inspector General (OIG), HRA, and MAA, as applicable. For serious reportable incidents, providers must prepare and submit an internal investigation of the incident to IMEU within five business days, and the IMEU must conduct its investigation and prepare an investigative report within 45 business days. The IMEU submits its investigative report for serious reportable incidents to the provider, Quality Trust, OIG, HRA, and the *Evans* Court Monitor and *Evans* parties, as applicable.

The reportable incidents (*i.e.* Level 3) are reported on the DDS Incident Report form and in MCIS, but the provider alone is required to conduct an internal investigation within five business days and

report to the DDS case manager assigned to the participant. Allegations of abuse or neglect for individuals over the age of 18 are also reported immediately upon identification to the Department of Human Services' Adult Protective Services unit, and for children under the age of 18 to the Child and Family Services Agency's Child Protective Services unit. In addition, deaths are investigated by a third-party contractor on behalf of DDS, and the Office of the Chief Medical Examiner (OCME), the MRDD Fatality Review Committee, and the Metropolitan Police Department (MPD) are included in the distribution, among the other agencies identified for serious reportable incidents, of the MCIS reporting and the final investigative report.

b. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Participants and their families receive a Fact Sheet regarding protections afforded participants, how abuse, neglect, mistreatment and exploitation is defined, and how to report such incidents upon intake and at the annual planning meetings. Provider agencies are also required to train and educate participants regarding abuse, neglect, mistreatment and exploitation and the methods to report the same as part of the new Basic Assurance Standards review expectations for District providers.

c. **Responsibility for Review of and Response to Critical Events or Incidents**. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

An IMEU Compliance Specialist ensures that all incidents submitted by providers in the MCIS are adequately completed within one business day. The Compliance Specialist contacts the provider or other reporter to ensure that all notifications to other government entities have been made (*i.e.* MPD, OCME, HRA, MAA, OIG, Adult Protective Services, Child Protective Services). The Compliance Specialist also verifies for all Level 1 incidents involving allegations of abuse, neglect or theft that the staff alleged to be involved in the incident have been removed from contact with DDS participants. Other serious reportable incidents and reportable incidents are triaged for follow-up investigation by the provider and/or IMEU, depending on whether the allegations are properly categorized as Level 1, 2 or 3. Level 1 (*i.e.* death, allegation of abuse, allegation of neglect, theft of personal property, and serious physical injuries) and Level 2 (*i.e.* serious medication error, improper use of restraints, emergency inpatient hospitalization, suicide attempt or threat, missing person, or 911 calls for law enforcement personnel, emergency medical assistance or fire) serious reportable incidents require a provider internal investigation within five business days of the incident and IMEU is required to conduct its investigation and prepare its investigative report within 45 calendar days. During its investigation, the IMEU assesses the provider's internal investigation. To the extent the provider's internal investigation and recommended remedial measures are deemed sufficient for Level 2 serious reportable incidents, the IMEU investigator may seek permission from the IMEU Chief for an administrative closure of the case based on the provider's internal investigation and remedial measures taken. For all Level 1 serious reportable incidents, and for all Level 2 serious reportable incidents for which an IMEU investigative report is prepared, an IMEU Compliance Specialist is assigned to monitor the provider's compliance with the recommended remedial measures. Level 3 reportable incidents are investigated by the provider alone and are reviewed periodically by the IMEU's Compliance Specialists for compliance with recommended remedial measures. These reviews by Compliance Specialists include evaluation of recommended follow-up activities and the DDS investigator reconciles any questions or concerns.

The IMEU submits its investigative report for serious reportable incidents to the provider, Quality Trust, OIG, HRA, MAA, and the *Evans* Court Monitor and *Evans* parties, as applicable, within seven days. The reportable incidents (*i.e.* Level 3) are reported on the DDS Incident Report form and in MCIS, but the provider alone is required to conduct an internal investigation within five business days and report to the DDS case manager for the consumer. Allegations of abuse or neglect for individuals over the age of 18 are also reported immediately upon identification to the Department of Human Services' Adult Protective Services, and for children under the age of 18 to Child and Family Services Agency's Child Protective Services. In addition, deaths are investigated by a third-party contractor on behalf of DDS and the OCME, DDS Fatality Review Committee, and MPD are included in the distribution of the MCIS reporting and the final investigative report.

Follow-up recommendations that result from an investigation are to be initiated or implemented within five business days of receipt of the IMEU investigative report and are verified by the IMEU Compliance Officer. Any recommendations not addressed and completed by the provider after receiving follow-up and support from the IMEU Compliance Specialist are referred to the Program Integrity Division to determine if technical assistance is required, if monitoring needs to be employed, and, if needed, the type of sanctions and or enforcement remedies that should be recommended. The Program Integrity Division reviews and prepares cases for submission to the newly created Compliance Coordinating Council where the member agencies (*i.e.* DDS, MAA, HRA and Department of Mental Health) can determine appropriate penalties and/or sanctions to impose to obtain compliance.

d. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

On a monthly basis, the DDS Quality Enhancement's Quality Improvement office (QI) conducts an overview analysis of data collected as part of the incident investigative process. On a quarterly basis, the QI, completes a review that evaluates and investigates trends of incidents, and develops and assures the implementation of corrective action plans to address identified trends and underlying concerns. Quarterly reports of incident reporting and findings from investigations are prepared by the Quality Enhancement Unit for dissemination and review by the Quality Improvement Committee, which includes external stakeholders such as family members, DOH/HRA , the Quality Trust and internal members including Case Management, IMEU, and others.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

a. Use of Restraints or Seclusion ***(select one):***

	The State does not permit or prohibits the use of restraints or seclusion. Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:
X	The use of restraints or seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii:

i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The District of Columbia established the Restrictive Control Procedure/Behavior Support Policy on November 1, 2001. This policy supports the development of environments that provide maximum positive supports to a participant's behavioral functioning that is responsive to the needs of participants' experiencing challenging behaviors, including symptoms of mental illness. This policy further provides guidelines for the development of Behavior Support Plans, and for the use of restricted controls as part of planned or emergency intervention to address challenging behavior. The policy describes in detail how a behavior plan should be developed. Any use of restricted controls may only be used with the consent and approval of the participant and/or participant's guardian/parent, the agreement of the Plan of Care team, and the written approval of a human rights and behavior management committee. Restricted Controls are permitted only when the following conditions apply: as a last resort, when proactive treatment strategies have been considered/attempted and would not protect the participant or others from harm, or prevent property damage; when other less intrusive or less restrictive methods have been ineffective; and, as a planned intervention in approved behavior support plans, or on an emergency basis under circumstances as defined by DDS policy.

Psychotropic medication shall also not be the first treatment of choice for behavior problems per this policy. Any psychotropic medication prescribed without a formal assessment and diagnosis of an Axis 1 mental disorder by a physician is considered as a "chemical restraint" which is prohibited by DDS policy. Use of PRN psychotropic medication is also not permitted per policy. Additionally, seclusion and mechanical restraint are prohibited by DDS policy.

Provider agencies are required to demonstrate the capability to develop appropriate and effective Behavior Support Plans and use restrictive controls appropriately. All providers must develop written policies for the development of behavior supports and use of restrictive controls per the DDS policy, and policies governing their agency's Behavior Support Committee and Human Rights/Quality Improvement Committee.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Oversight and compliance with this policy begins with the Plan of Care Support Team. The Team must assure that all behavior assessments have been completed, appropriate medical interventions have been investigated, all adjustments in the Plan of Care have been made, and all environmental changes have been investigated prior to determining that a behavior support plan is warranted. Staff that implement a plan that contains restrictive controls must be trained in a DDS approved Crisis Intervention program that emphasizes positive practices, de-escalation techniques and non-aversive behavior support techniques. Plans that contain restrictive controls are subject to, at minimum, annual review and approval by both provider agency Behavior Support Committees (BSC) and Human Rights/Quality Improvement Committees (HRC) as well as DDS's Restrictive Control Review Committee (RCRC) and Human Rights Advisory Committee (HRAC). DDS committees regularly review the work of agency BSC and HRC committees by reviewing minutes and tracking actions, thereby ensuring that agency committees are conducting appropriate reviews and planning for the decrease and elimination of restrictive controls.

Emergency use of a restricted control must be reviewed by a licensed psychologist and the Provider Agency Director within 24 hours. An incident report must be made and investigated by the agency, be tracked as needed and be reported to the DDS case manager.

DDS's Human Rights Advisory Committee has the Restrictive Control Review Committee as a sub-committee. The RCRC is comprised of no more than nine members, including one individual receiving services from DDS, one family member of a participant receiving services from DDS, a residential provider, a day habilitation provider, an MR/DD advocate, a psychologist or psychiatrist with expertise in behavioral supports, and one or more DDS nurses or medical doctors The RCRC reviews all uses of restrictive controls as they pertain to a participant; reviews all requests for one-to-one staffing to ensure that it is the least restrictive alternative and that there is a plan, as appropriate, for reductions in one-to-one support. This review will follow the review by a pre-referral team consisting of a participant's case manager following an ISP approval process, a nurse or physician, a finance designee, and a behavioral specialist, if the request is for behavioral reasons; reviews all requests for services that exceed the approved maximum hours allowed in the Medicaid Waiver rules; makes recommendations for policies, procedures, practices and/or strategy changes that lead to reduced restrictive controls and more positive behavioral supports; within 24 hours, makes recommendations to the HRAC and the DDS Director for corrective actions and technical assistance to provider agencies who inappropriately utilize restrictive controls; provides minutes of its monthly meetings to the HRAC and send a representative to all HRAC meetings.

b. Use of Restrictive Interventions

X	The State does not permit or prohibits the use of restrictive interventions. Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

	The following practices are prohibited per the Restrictive Control Procedures/Behavior Support Policy: Any prohibition of contact with a guardian, family, attorney, probation officer, regulatory or advocacy personnel, or religious representative; any procedure or action which is degrading, humiliating, harsh, or abusive; any form of corporal punishment or systemic aversive conditioning; subjection to unclean, unsafe and/or unsanitary living conditions; the use of seclusion or secured time out rooms; the use of mechanical restraints, as defined in the policy; the PRN use of psychotropic medications, and all forms of chemical restraint as defined by this policy; deprivation of opportunities for bathing, toilet use, or other forms of basic hygiene; deprivation of needed health or mental health services; systemic deprivation of sleep or rest; withholding of incoming or outgoing mail; and, disciplining of participants by other participants or the implementation of one participant's behavior program by another participant. The Incident Management and Enforcement Unit (IMEU) reviews all incident reports. Any emergency use of a restrictive procedure or instance of abuse, neglect or mistreatment is immediately investigated by DDS's IMEU to assure that appropriate positive behavioral supports or approved restrictive controls are in place if needed. Such incidents are closely tracked and monitored for any repeated trends. Also, the Office of Program Integrity monitors programs to ensure that quality standards and systems are in place and reports any instances of inappropriate or unapproved behavior support, abuse, neglect or mistreatment they observe to the RCRC or HRAC as appropriate. Similarly, case managers, nurses and licensing agencies report on the same issues they may encounter to the RCRC or HRAC as appropriate.
C	The use of restrictive interventions is permitted during the course of the delivery of waiver services. Complete Items G-2-b-i and G-2-a-ii:

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

X	**Yes**. This Appendix applies *(complete the remaining items).*
O	**No**. This Appendix is not applicable *(do not complete the remaining items).*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

In locations where participants require assistance with medication administration, medication regimens are reviewed every thirty days by the supervising RN. This review includes a review of the prescribed medications and treatments and a review of the medication administration records. DDS completes a Health Risk Assessment and prepares a Health Care Management Plan for each participant that includes critical information regarding medication, other treatments and health care needs. The DDS case manager reviews this plan during each monitoring visit for continued accuracy and to monitor if health care needs are being carried out medication. The frequency of these visits ranges from 8 to 12 (monthly) times a year depending upon the needs of the participant. The Case Manager Monitoring Tool is used to structure and document the review. The Alert process is initiated if a case manager identifies any concerns. An Alert is entered into the DDS Alert data system and is directed to the appropriate clinical, investigatory or technical assistance unit in DDS for action. Participants identified as High Risk for health reasons are monitored by a DDS Nurse at a frequency determined by the Chief of Clinical Services (Policy for Registered Nurse Monitoring of Individuals Identified as High Risk, MRDDA Policy 10.2, effective 10/10/06). The High Risk Review protocol is used and documented for each participant. The High Risk Review is conducted along with the DDS case manager, who again would initiate the Alert process is any component of the participant's plan or overall care was found to be deficient.

The use of medications to manage behavior is also governed by the MRDDA Policy on the Use of Psychotropic Medications effective November 1, 2001. This policy establishes the guidelines, protocols, procedures and oversight mechanisms for the use of psychotropic medications for DDS participants. The use of psychotropic medications may only be permitted if the participant has an Axis 1 diagnosis and its use must be incorporated into the participant's Behavior Support Plan and approved through the DDS Human Rights Committee process. Participants who use psychotropic medications prescribed must be reviewed monthly by the psychiatrist. Informed consent is required from the participant and/or family member or guardian. If no family member or guardian is available and informed consent cannot be provided by the participant, then the participant's team must locate an alternate surrogate decision maker. If the participant is not supported by a residential provider, the case manager is responsible for monitoring the participant's response to the medication and any suspected side effects, and submitting DDS Psychotropic Medication Monitoring Form to the prescribing psychiatrist for the monthly monitoring. Additionally, a nurse or psychiatrist must complete an assessment for tardive dyskenesia at least every 6 months. The case manager is also responsible for informing the day/vocational

provider of any changes.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

DDS, DOH and MAA all review medication management during each agency's respective review process. DDS reviews the provider's compliance with all medication management and administration practices during the Basic Assurances review. DDS also monitors Incident Reporting that surfaces through the Incident Review Committee. Incidents may reveal adverse reactions from medication use, improper use of psychotropic medications, an increase in behavioral incidents, and an increase in the frequency of unanticipated hospitalizations or use of emergency medical services as examples. Any trend or incident that raises concern is followed up by the case manager, or a nurse or clinician from DDS and tracked for resolution by Unit supervisors through the Alert system.

DOH/HRA licensing of Chapter 35 regulations in group home settings also includes medication review. Deficiencies in any area are reported through the licensing visit documentation and forwarded to DDS. The DDS Quality Improvement Unit assures the completion of an acceptable plan of correction, and offers technical assistance to manage the plan of correction process as needed.

MAA also completes a record review including medication administration and management on a quarterly basis as part of that Unit's oversight activities. MAA reports are shared with DDS; DDS is responsible for appropriate follow-up for participants and/or systemic issues identified at the service location, provider or District system at large.

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one*:

X	Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*
O	Not applicable (*do not complete the remaining items*)

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Medication Administration and Self-Administration is governed by DC Municipal Regulations Title 17, Chapter 61. Staff that seek certification to administer medications must pass a CPR course for health care providers, a First Aid course, submit a police clearance and pass a Medication Administration course approved by the DC Board of Nursing. Staff must pass the written exam with no less than 80% correct, receive a score of 100% in the practicum, and have at least one year of experience. Medication administration records (MAR) must include the name of the participant, name of the program, the month and year the medication is prescribed for administration, the primary and secondary diagnosis, any known allergies of the participant, the diet order for the

participant, the name of the licensed practitioner under whose care the participant has been placed, the name of the supervisory registered nurse responsible for the review and preparation of the MAR, and the supervision, monitoring and delegation of nursing functions with respect to the participant. All new medication orders must be reviewed by the supervisory nurse within 24 hours.

Serious or multiple medication errors must be reported by the supervisory nurse to the DC Board of Nursing within 24 hours, in addition to the report to DDS. The Board notifies the staff person that a written response to the error must be submitted within 3 business days. The Board may require the staff person to re-take the class and practicum. After two such findings, the staff person will lose the certification to administer medications. General re-certification is required every two years. On a monthly basis the supervisory nurse must document the staff person's compliance with the proper administration of each participant's medications, and their ability to monitor signs and symptoms, and demonstrate proper storage and clean up techniques. Each staff person must receive 24 hours of in-service training each year from the supervisory nurse.

Participants may also self-administer their medications. An initial assessment is completed to determine to determine the level of support the participant requires in the area of medication administration. The three options are participant self-administration, administration of the medication by a trained staff person and administration of the medication by a LPN or RN. If the participant is found to be capable to self-administer, the participant is re-evaluated on a monthly basis to assure continued capacity to self-administer their medications.

iii. Medication Error Reporting. *Select one of the following:*

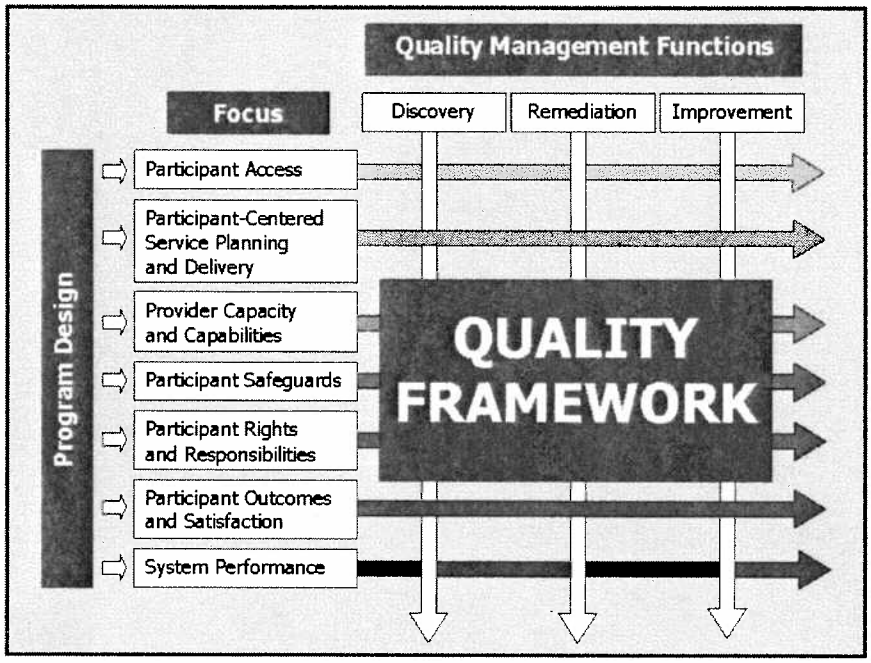
X	Providers that are responsible for medication administration are required to *both* record and report medication errors to a State agency (or agencies). *Complete the following three items:*
	(a) Specify State agency (or agencies) to which errors are reported:
	DDS receives all incident reports. The District Board of Nursing also receives incident reports when the medication is administered by unlicensed staff.
	(b) Specify the types of medication errors that providers are required to *record:*
	1. Wrong Person; 2. Wrong Medication; 3. Wrong Dose; 4. Wrong Route; 5. Wrong Time; 6. Failure to Administer; 7. Failure to properly record; 8. Administered by an unlicensed staff person who has not completed medication administration training; 9. Instances of Side Effects; and 10. Physician or Pharmacy Error.
	(c) Specify the types of medication errors that providers must *report* to the State:
	1. Wrong Person; 2. Wrong Medication; 3. Wrong Dose; 4. Wrong Time; 5. Failure to properly record; 6. Administered by an unlicensed staff person who has not completed medication administration training; and 7. Instances of Side Effects.
O	Providers responsible for medication administration are required to *record* medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The DC Nursing Board receives incident reports from the supervising Nurse in a provider agency and may conduct an investigation. If a staff person has made a serious error or has a pattern of errors, the certification to administer medications may be removed. DDS monitors medication administration through incident report trend analysis, during the Provider Basic Assurances review, during case manager monitoring visits and during nursing reviews completed for participants identified as High Risk. DOH/HRA Licensing activities also include review of medication administration practices; DOH/HRA reports any deficiencies to DDS for follow-up action and resolution.

Appendix H: Quality Management Strategy

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.



- Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Management Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS, a state spells out:

- The evidence based *discovery* activities that will be conducted for each of the six major waiver assurances;
- The *remediation* processes followed when problems are identified in the implementation of each of the assurances;
- The *system improvement* processes followed in response to aggregated, analyzed information collected on each of the assurances;
- The correspondent *roles/responsibilities* of those conducting discovery activities, assessing, remediating and improving system functions around the assurances; and

The process that the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the State plans to undertake during the period that the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Management Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

Attachment #1 to Appendix H

The Quality Management Strategy for the waiver is:

The District of Columbia, Department of Developmental Disabilities (DDS) has designed and initiated a comprehensive revision of its quality assurance and improvement systems. In the DDS, the Program Integrity Division will lead this overall effort, and is comprised of the Quality Improvement (QI) Branch and the Basic Assurance (BA) Branch. This Division plays a major role in the overall quality management strategy for the waiver program. The Quality Enhancement (QE) Division is charged with the following: reviewing the DDS service delivery system, identify areas in need of improvement and engaging in continuous quality improvement through data analysis and trending/tracking of different data streams within DDS; and, providing technical assistance to DDS and the provider community in licensure, certification and basic assurances, and ensure the essential elements of ongoing quality improvement and management. The Basic Assurance Branch carries out DDS's new Basic Assurance Authorization Process, the quality review process to evaluate DDS providers of service. DDS has re-established the Quality Improvement Committee (QIC) as a standing committee responsible for reviewing the quality of the District's service delivery system, identifying broad areas of improvement, and following the implementation of recommendation. All reports are disseminated to the DDS Management Advisory Committee and MAA. The following sections of the Quality Management Strategy detail the activities and functions of these entities.

I. Six Assurances

A. Level of Care: Initial determinations are reviewed by the DDS Waiver Unit and MAA prior to finalizing enrollment in the HCBS waiver. The BA Branch conducts a monthly audit of the Level of Care determination (initial or re-determination) through a random 2% sample audit on a monthly basis. This audit confirms that the LOC determination was completed on a timely basis, that the required evidence for making the determination is present in the record and that the determination was made accurately based on LOC requirements as described in the waiver. Findings are referred back to the Waiver Unit when individual discrepancies are identified and entered into a tracking database. The Waiver Unit reports back to the QE Division when the discrepancy has been corrected and the finding is closed in the data system. The QE Branch aggregates data and presents findings to the QI Committee at least quarterly on trends identified in the completion of LOC determinations and in the remediation of determinations where discrepancies were identified. Weaknesses in either timeliness or accuracy are referred for re-training or enhanced oversight as indicated. All findings are shared with MAA on a quarterly basis. The Performance measures are collected in three areas:

a. Percentage of LOC determinations completed as a % of all DDS eligible individuals;
b. Percentage of audit sample with a LOC re-determination completed within 365 days; and,
c. Percentage of audit sample with completed Freedom of Choice form completed during the LOC determination (Choice between waiver services and institutional care).

Baseline data will be collected May 2007 through October 2007, and QI goals will be set for each year of the waiver.

B. Participant-Centered Planning and Service Delivery (Service Plan):

The District is engaged in a Quality Improvement initiative to develop a new unified Plan of Care (POC) to coincide with the requested start date for this waiver application. In addition to a new POC, the District is evaluating options for a Risk Screening Tool or process, and has adopted the Supports Intensity Scale as a uniform assessment tool to identify support and service preferences and needs. Case Management Supervisors are responsible for tracking the timely completion of POC's. The DDS Waiver Unit reviews all POC's as part of the service authorization process. The QE Branch completes a 10% random sample audit of service authorizations on a monthly basis. The Quality Improvement Specialist uses four different

discovery methods to determine if each service as authorized in the POC has been implemented per the prescribed scope, duration and frequency. Each service must be verified by at least three out of four of the following probe techniques: interview with the individual receiving services, the case manager and the provider,and a review of the record. Findings are entered into the QE database and forwarded to the Waiver Unit, and problems in service delivery are noted for remediation by the case manager and/or the waiver unit. The Waiver Unit is responsible to follow-up on all identified concerns and report back to the QE Branch within 30 days of the report.

During the Basic Assurance Authorization Review, the Compliance Specialist will also verify that POC's are implemented as written, and are changed as appropriate based on the changing needs and preferences of the participant. (See III. Qualified Provider below). The standards include health, rights, safety, staff resources and support, and positive services and supports. Samples will vary depending on service type, service locations and number of participants supported by each provider/vendor [Individual participant concerns indicating a Plan of Care development or delivery weakness will be recorded in a database for remediation to be addressed or monitored by the DDS Case Manager or DDS clinician through the Alert System. Individual concerns will be pointed out to the provider for immediate correction. In the case where the provider/vendor has not met the standard related to delivery of services per the POC, the DDS Quality Improvement Specialist will support the provider/vendor with technical assistance as needed to address the systemic concerns as noted. The following Performance Measures will be collected:

a) % of people whose POC reflects the participant's desires and goals based on individual preferences;
b) % of participants who receive the required medical/clinical assessment and intervention as required by physician's order;
c) % of participants who have current and individualized Health Management Care Plans that support all physical and emotional health care needs;
d) % of participants whose POC contain all required DDS elements per policy;
e) % of participants whose POC support objectives are implemented; and
f) % of participants whose POC goals and services are evaluated annually and/or modified as necessary.

Baseline data will be collected May 2007 through October 2007, and QI goals will be set for each year of the waiver.

C. Qualified Providers

Initial Provider Enrollment procedures carried out by DDS assure that a provider meets required licensure and policy standards prior to submission of the Provider Medicaid Application request to MAA. DDS reviews policies, staff training, applicable licensure, certifications, and insurance documents. The application is forwarded to MAA for final approval.

DDS has developed and will begin implementing in May 2007 a new Provider performance review process: the DDS Basic Assurance Standards. Providers will be measured in seven areas: Rights, Protection and Promotion; Dignity and Respect; Protection from Abuse, Neglect and Mistreatment; Best Possible Health; Safe Environments; Staff Resources and Supports; and Positive Services. The review process serves as a certification process for authorization to operate under the waiver program, measure performance, ensure minimum standards are met, and to ensure the provider is able to deliver participant-centered services and supports as a best practice. The Basic Assurance Authorization Unit in the Office of Program Integrity carries out the review process.

New providers must apply for a Basic Assurance Standards Authorization process within 30 days of beginning service delivery. Existing providers will be placed on a schedule of review by DDS. The review

process is comprised of two parts; a pre-on site review of policies, and compliance with applicable licenses, executed Human Service Agreements and adherence to required District codes as indicated in Title 22-Chapter 137 and Title 22, Chapter 35. The on-site review selects a sample of participants receiving services from each service type offered, and a visit to a sampling of physical locations operated by the provider. Each of the seven areas has performance measures assessed through a combination of provider interview, participant interview, documentation review and observation. To meet each of the Assurance Areas, at least 90% of the performance measures must be met to achieve a one year certification for each service type offered by the provider.

If a provider fails the initial authorization, the Basic Assurance Unit will provide technical assistance as needed. The provider will be re-evaluated after 60 days. If the provider passes at that time a one-year Authorization will be granted. If unsuccessful, a third review occurs after an additional 30 days. If the provider passes this third review a Probationary Authorization is granted for a period of nine months. Providers in the Probationary status are required to submit a status report on quality assurance and improvement every month for the first three months and quarterly thereafter. The DDS Program Integrity Unit will provide technical assistance and conduct additional on-site visits to assess the progress in those areas where the provider had weaknesses.

A provider who fails at the time of this third review will no longer be authorized to provide services, and DDS will proceed to implement procedures in accordance with the DDS/MAA Memorandum of Understanding to de-authorize the provider. Notification of this action is provided to the DDS Administrator and any other District regulatory agencies that have jurisdiction. DDS will take immediate action to assist individuals supported by the provider to locate other providers for all services.

Select performance measures in each area include:

a) The Provider has policies and procedures in place for each of the Seven Areas;
b) The Provider trains all staff in each of the Seven Areas;
c) The Provider has guidelines for staff to help participants learn about and choose to exercise the rights and personal freedoms important to them;
d) The Provider has an established Human Rights Committee;
e) The Provider encourages participants to express dissatisfaction or talk about any problem they experience;
f) The Provider assures that each staff person learns about and supports needed for privacy
g) Provider activities, goals, and strategies are meaningful and are results oriented for each participant;
h) The Provider maintains an Incident Management Coordinator who reports, investigates and analyses all incidents that do or could cause harm;
i) Participants services are provided training/education on identifying and seeking help for abuse, neglect, mistreatment and exploitation;
j) Participants receive required medical/clinical assessment and intervention as needed;
k) The Provider has policies and procedures that include health risk management;
l) Substitute medical consent is obtained and ready in the event it is needed;
m) All medications and treatments are provided as indicated for best health
n) Physical environments are determined to be safe;
o) Policies and Procedures are in place to respond to potential emergency and disaster situations;
p) The Provider maintains a current Plan of Care on record and assures the staffing pattern is in place;
q) Service goals are implemented in a timely manner;
r) Participants are provided positive behavioral supports, and if restrictive procedures are deemed necessary there is Human Rights oversight in place.

A complete listing of performance measures can be found in DDS Basis Assurance Policy 11.3 and associated Operation Procedures.

The Quality Improvement Unit in Program Integrity also monitors and provides technical assistance to providers who have had citations from an Health Regulation Administration (HRA) review. Providers may also seek technical assistance from this Unit at any time to improve on any area of operations.

D. Health and Welfare

DDS employs a health risk screening for all participants. Those identified as high risks have their health care monitored by Registered Nurses (RNs) through the DDS Clinical Services Division. Monitoring tools are developed which include recommendations for the improvement of the health care of the participant. RN's will follow-up monitoring visits to ensure recommendations are carried out. During those reviews the medical record, the Health Care Management Plan, consultations, specialty protocols, laboratory and diagnostic data are reviewed. The Chief of Clinical Services establishes the frequency of the health monitoring for each participant.

Participants identified as being at high risk due to medical, psychiatric, behavioral issues, or actively involved in the criminal justice system are assigned to Intensive Case Management services. A Plan of Action (POA) is developed which identifies the goals and outcomes of intensive case management interventions, strategies, timelines, responsible person for providing the interventions, frequency of visits and target time frames. Participants also have a Health Care Management Plan (HCMP) monitored by a RN to ensure services are provided as prescribed in the plan.

DDS conducts Health Status Reviews to verify the accuracy of the medical health profile; accuracy of the Health Care Management Plan and that knowledgeable staff are implementing the participant's HCMP. The case manager and the RN carry out the review and monitoring of health status. If during a review the absence and/or deficiency of a needed service and/or support present an immediate jeopardy to the health, safety and welfare of the participant, a Level One Incident is called and all parties are alerted within 8 hours. A Corrective Plan of Action is developed, and submitted to the Branch Chief for approval. Documentation regarding the incident is submitted to the Branch Chief and entered into the MCIS with weekly Plan of Correction progress tracked in the system.

All individuals receive case management visits. During the case manager site visit, the following measures are assessed:

1. Participants have the same rights and protections as others in the community.
2. Participants are treated with respect and dignity
3. Participants are free from abuse, neglect and injury
4. Participants live and work in safe environments
5. Participants' funds are secure and used appropriately
6. Participants are supported to have the best possible health care services
7. Participants' medication are prescribed and administered appropriately
8. Services are provided according to Participants' POC's.

DDS case managers may call upon the Quality Improvement Unit when deficiencies or concerns are noted during the site visit. The QE Division Chief reviews and approves the request for technical assistance. A Quality Improvement Specialist from that Unit is assigned to provide technical assistance to the provider and to monitor the issue until resolved. All issues are entered into a data base for tracking accordingly.

As described in Appendix G, all incidents and alerts are reported to DDS. The Quality Enhancement Unit manages the Incident Review Committee functions and data analysis teams to support DDS in providing reliable information that is analyzed and reported in ways that enhance services to people. The Incident Report Committee prepares monthly reports of all incidents and activities. Reports are distributed to the DDS Administrator, DOH/ MAA and the Health Regulation Administration. As needed the information is also forwarded to the Basic Assurance Unit, Case Management Unit, Incident Management and Enforcement Unit, Mortality Review Committee, Quality Improvement Committee and the Waiver Unit.

DDS also employs a Fatality Review Committee co-chaired by the Office of the Chief Medical Examiner (OCME) and the DDS Administrator. Meetings of this Committee are held to conduct case reviews or assessing individual data from prior cases that have since become available, to consider recommendations arising from available case reviews, to prepare an annual report and to conduct any other business so deemed necessary to fulfill its duties.

A critical component of the Data Integration Unit within Quality Enhancement is reporting on recommendations, follow-up and resolution. This unit collects data from Mortality Review, Fatality Review, Case Management, and Incident Reporting. Monthly reports are sent back to each unit and are presented to the Quality Improvement Committee for further trending and analysis. The Quality Improvement Committee makes recommendations for systemic quality improvement. Quarterly reports are submitted to the Administrator for further action and consideration. Data reports are also used to work with Providers in quality improvement efforts. Specific data points are being trended by the QE Unit as measures of performance. They include: 911 calls; emergency inpatient hospitalizations; abuse; neglect; physical injury; death; serious medication error; improper restraints; 1:1 incidents; theft of property; and, improper use of psychotropic medication.

E. Fiscal Accountability

ASSURANCE	MONITORING ACTIVITY	MONITORING RESPONSIBILITES	DATA/REPORTS	FREQUENCY	TIMELINES
State Medicaid Agency conducts routine, review of expenditures and claims to ensure that all claims are coded and paid in	Monitoring of Claims from ACS Government Health Care Solutions	• ACS\Program Operations • DDS • SURS	Claims reports Reviews total expenditures for a six month period DDS High Volume High Cost Problem Prone Cases	Monthly two different Service Providers Reviewed	Ongoing

waiver	Review expenditures for codes of DDS waiver participants	DDS	372 reports Review Exception reports as needed Claims details Report to SURS as needed	Annual As Needed	Ongoing
ISP cost sheets are appropriate services at rates approved	Service Plan review of admission cost sheet of each new participant to waiver	• DDS (Final) • Case Manager	Cost Sheet request in admission packet	On admission On change of service On recertification	Ongoing
Claims are billed according to ISP (cost sheet)	Claims Review	• DDS • Surveillance Utilization Review (SURS)	Claims Report DDS report as needed	Monthly review of two Home Health Agencies for claims cost of numbered participant select at least 5 participants to assess cost	Monthly
Quality Indicators	Cost of	• Claims report • ISP Cost Sheet	AD-HOC Report	Monthly	Ongoing

St _____
Ef _____

Atta

	participant services Number of participants billed for Services billed vs. services approved		DDS report as needed		
State Financial oversight for the fiscal management system claims are paid in accordance with the reimbursement methodology	Audits of claims and reconciliation of submission and denials.	• Provider • SURS	Claims Data reviewed DDS reports as needed	Quarterly	Ongoing
	Review of Expenditures/cost overruns	• DDS	Claims Data - Expenditures Reports Cost Reports	Quarterly	On-going

The Quality Enhancement Unit conducts a 10% random sample of service utilization authorizations. The Quality Specialists verify that services are delivered as prescribed for each person through observation, document review, case manager interview and consumer review. Three out of four sources of verification must affirm the service delivery and billing. Findings are reported to the DDS Waiver Unit for follow-up actions. Remedies to reported problems fall into the following categories:

Reported Problem: Poorly written goals and justifications statements that make assessing outcomes difficult.
Follow-up Action: The DDS Waiver Unit provides technical assistance for the provider, case manager, and participant to develop goals and justifications that establish performance expectations.

Reported Problem: Provider is not providing the services that have been prior authorized.
Follow Up Action: The DDS Waiver Unit verifies if the provider agency is claiming based on the prior authorizations. If the provider agency is claiming that will be reported to MAA for follow up action on Medicaid fraud. If the provider is not claiming, the DDS Waiver Unit contacts the participant receiving the services and the case manager and requests clarification. Technical Assistance is provided if the service needs to be modified. Also, if the provider is not claiming, the DDS Waiver Unit Provider Relations Office will contact the provider for clarification and make sure that the prior authorization was received. If the prior authorization was not received it will be sent again and confirmed. If the provider is declining to provide the service without having notified the participant receiving the service, they will be notified of the requirement for two week notice before stopping service. If the provider cannot contact the participant receiving the service, contact will be facilitated. If the provider still declines to provide service they will be reported to MAA for an audit and performance review.

DDS Enforcement Plan: At the inception of this waiver, DDS is adding enforcement capabilities based on performance and refusal to provide adequate services that will allow DDS to take action without MAA approval.

MAA manages the MMIS system and prepares monthly reports for the DDS Administrator and the CFO of DHS. Claims are checked against current Medicaid status and LOC determinations. The MAA Fraud Unit may be dispatched upon request by DDS, HRA and/or MAA when a billing discrepancy is noted.

F. Administrative Authority

DDS and MAA have entered into a Memorandum of Understanding that establishes the terms and conditions under which DDS shall coordinate and administer the HCBS waiver. MAA is responsible for managing the MMIS system and providing regular reports on claims paid, status of the DDS account; projections for spending, and maintenance of slots. MAA is responsible to provide technical assistance to DDS staff on provider certification and enrollment processes, providing on-going training as needed and issues Medicaid Provider numbers for those providers who have acceptable provider enrollment packages. MAA is also party to an MOU between DDS, DOH, DMH, and the Office of Contracting and Procurement that establishes the terms and conditions under which the parties will coordinate enforcement mechanisms to ensure DDS provider compliance through the OCP contracting officer under human care agreements, licensure of homes under HRA, and MAA oversight of the Medicaid Program.

MAA receives monthly and quarterly reports on incident management, investigations, site visit follow, mortality review and results of HRA and DDS provider reviews. MAA meets with the DDS Administrator on a quarterly basis to discuss any significant findings and participate in joint problem solving. MAA approves all DDS policies and procedures and rules relative to the operation of the DDS Waiver program. MAA also completes chart audits for a 10% sample to monitor level of care decisions, sufficiency of the Individual Plan based on person-centered principles and support service authorizations, and provider documentation to support billings and maintenance of provider enrollment requirements

II QUALITY MANAGEMENT STRATEGY: ROLES, RESPONSIBILITIES, PROCESSES, REPORTING AND RE-EVALUATION

The DDS Quality Enhancement Division is responsible for establishing protocols and procedures for the Quality Enhancement System and its associated units under DDS. One major component of this system is data integration. Incidents and corrective actions are tracked and reports prepared for the DDS Administrator, MAA, and HRA on a monthly basis. Qualitative and quantitative data is also collected to measure unit performance within DDS. Information collected includes: incidents and alerts; waiver service authorization reports; basic assurance review findings; mortality review findings; Nursing Review results; HRA findings; Court Monitor reports; and other technical or administrative reports. Mortality Review and Fatality Review are prepared for analysis and consideration on a quarterly basis, and reported to DDS and MAA administrators.

Two committees have been established to provide a mechanism for oversight and quality improvement. The Quality Improvement Committee (QIC) has been re-established as a standing committee within DDS. The QIC is responsible for reviewing the quality of the District's service delivery system and identifying broad areas in need of improvement. The QIC will also examine integration, coordination, and capacity aspects of the District's service delivery systems' components, including interdepartmental consumer issues. The QIC is designated as the body responsible for systems renewal and continuous quality improvement, with a focus on provider and system issues and trends rather than individual consumer issues. The QIC is chaired by the Chief of Quality Enhancement, and is comprised of the following:

- DDS Deputy Director of Programs
- DDS Deputy Director of Program Integrity
- DDS Deputy Director of Program Support
- Representative from Case management
- DDS Chief Investigation Compliance and Enforcement
- Representative from DOH, Health Regulation Administration
- Representative from the Quality Conference
- People with disabilities, advocates and family members (2)
- Representative from the DDS Office of Human Rights
- Representative from Health Resource Partnership
- Representative from the Quality Enhancement Unit
- Representative from Information Technology

The QIC is responsible for providing the DDS Director and executive management with recommendations concerning goals, objectives and strategies designed to enhance/improve:

- The service system's responsiveness to consumer needs;
- The service/support performance at provider and systemic levels; and,
- The integration and coordination of best practices and standards.

Recommendations can be made at any time based on reported findings and analysis

The larger stakeholder community and public are represented by the DDS Management Advisory Committee established by the DDS Administrator. This committee is comprised of:

- DC Council Member
- The Quality Trust
- The DD Council
- DDS Administrators
- The DC Provider Coalition
- The Arc of DC
- Three consumer representatives, two from Project Action
- Three Provider representatives
- 3 parents

- Representative of Georgetown University Center

The DDS Administrator presents information, reports and analysis for discussion and quality improvement recommendations.

Appendix I: Financial Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

INDEPENDENT AUDIT OF PROVIDER AGENCIES?

DDS conducts a service authorization audit for a 10% sample of all waiver participants on a monthly basis. The Quality Improvement Unit verifies that the service(s) was initiated in a timely manner, and through an on-site verification process confirms that the service was in fact delivered by confirmation through at least three our of four methods: case manager interview; participant interview; record review and observation of the service delivery. Deficiencies or concerns are reported to the DDS Waiver Unit for follow-up.

Claims for the DDS waiver services are based on approved services that have been rendered to waiver participants, authorized in the Plan of Care and billed by the appropriate agency representative. Independent audits heretofore have not been required. However, the DC Office of the Inspector General conducts audits, as indicated. To monitor the financial billing of the agencies, monthly claims are available from the fiscal intermediary, currently ACS Government Healthcare Solutions. All claims must be requested. DDS is currently developing a fiscal billing audit process for implementation prior to the requested start date of this waiver. The process will closely mirror the Elderly and Persons with Disabilities (EPD) waiver program administered by MAA.

Monitoring: The MAA fiscal intermediary tabulates the expenditures of each agency on a monthly basis

1. DDS reviews each participant's cost of services at the initial service request and during change of service request.

2. DDS reviews at least two agencies each month. A 10% sample of all claims/expenditures is requested from ACS at the beginning of each month. Indices of services on claims reviewed are:
   - Unduplicated participant;
   - Average payment per participant;
   - Claims count; and
   - Total sum service.

3. Agencies reporting high dollar expenditure and low numbers of participants or where other discrepancies seem to exist are first reviewed by DDS Waiver Unit staff. If irregularities are confirmed, DDS will refer the case to the MAA Surveillance and Utilization Review System (SURS). Additional triggers for review are:
   - Providers whose acuity fall outside of the norm (exceptional file);
   - Low utilization of approved plan; and
   - Hospitalization claims of DDS Waiver participants.

4. The District submits annual CMS 372/373 reports

5. Chapter 42 of Title 29 of the District of Columbia Municipal Regulations (DCMR)- entitled "Home and Community-based Waiver Services for Persons who have Developmental Disabilities"- are the rules which govern reimbursement by the District of Columbia. These rules are available to the public.

MAA completes a sample review of (5%?) of participants on a quarterly basis as a component of the Medicaid Agency Oversight. This review includes a financial audit component to verify documentation sufficient to justify billing and additional quality measures relating to provider participation requirements.

MMA -Identify the entity that is responsible for conducting the periodic independent audit of the waiver program as required by the Single Audit Act.

APPENDIX I-2: Rates, Billing and Claims

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Rate Methodologies for the Department of Developmental Service – April 2007

The District of Columbia MAA Office of Audit and Finance is responsible for all rate development with the assistance of program staff from the Department of Developmental Disabilities. Together, MAA and DDS staff develop rates for each DDS waiver service. The rate information is available to participants upon request and is available on the www.adrcdc.org website. The rate process includes market analysis as well as:

1. A review of rate structure in surrounding jurisdictions: (Maryland, Virginia and Delaware) is conducted;
2. Analysis of rate methodologies used in Maryland, Delaware, Arizona, Connecticut, Louisiana, and Washington State;
3. Meetings held with providers and community stakeholders to assess any outstanding issues as well as provide information and receive clear understanding of community needs and concerns;
4. A review and comparison of prevailing rates for specific services offered under the State Plan benefits; and
5. A review and assessment of expertise and capacity of providers and services.

Rate information for Medicaid participants and community members is provided on-line through the www.adrcdc.org website. Transmittal Letters from the MAA Director are sent to each provider indicating any changes or modifications in rates and rate structure.

Waiver service rates are closely evaluated based on a geographic market analysis. This includes a

review of service providers across the District of Columbia, Suburban Maryland and Northern Virginia within each of the Waiver services. Each service is reviewed and compared to providers offering services in surrounding jurisdictions and to geographic differences and provider supply. There is no automatic inflation increase. In January 2006 direct care worker rates (excluding nursing) were adjusted to provide a more realistic rate in line with neighboring jurisdictions and consistent with a DC Council mandate to provide a rate more acceptable for direct care workers, specifically a living wage rate. The change in rate was designed to stabilize the pool of workers. A review of the industry indicated that there was significant turnover of workers based on low wages and no benefits. This information was also factored into the rate increase as described below.

DDS has researched other DD Waiver state programs for customary rate development models in use. This waiver application contains several new services designed to improve the quality of care, and increase options for successful community living. The District holds as a high priority the need to attract new qualified providers of services, the need to have logical rate structures that can support the specific needs of participants, and the need to add new service model options. Additionally, the District is aggressively analyzing its current methods of payment to providers where local funds are used rather than waiver services. As the District does not require cost reports under the waiver, other states where such data exists were used in cost modeling exercises. In some cases, services that had been offered in one setting, such as Independent Habilitation, Attendant Care and Skilled Nursing, were confusing and difficult to audit. New rates are under development that would encompass the traditional support for care and supervision outside of the family home taking into account habilitation time needs, support and supervision needs and medical or behavioral clinical oversight supports under Residential Habilitation and Supported Living services in the DDS waiver application.

The rate models for hourly unit services are comprised of: an average wage for the staff person based on US Bureau of Labor Statistics (BLS) data and neighboring jurisdictions; an average percentage for mandatory and optional employee related expenses (FICA, FUDA, Worker's Comp, health insurance, etc) drawn from practices and data in the aforementioned states; a standard percentage of indirect costs related to supervision, training, clinical oversight and support, from data available in the District for costs paid using local dollars under Human Care Agreements and from other states; and, a standard administrative percentage. In facility-based day habilitation, pre-vocational and supported employment programs a factor is added to address physical plant requirements, attendance factors, and is further adjusted for participant needs as it relates to the size of the group in facility-based pre-vocational and day habilitation programs and group supported employment services. Additional factors are also incorporated for group living settings, again which reflect the size of the home or number of participants who reside in geographic proximity and take into account the specific support needs of the participant as it relates to the group. These will be represented by a daily per diem.

Companion care assumes no more than 4 hours of direct support is provided to the participant per day. Host Home rates are based on practice in other states, using a acuity based rate as a set percentage of the SL daily rates.

A transparent rate methodology that identifies specifically what is covered in the rate will permit new providers to make sound judgments about their ability to deliver quality service in the District. Some rates will be increased as they had not previously factored in indirect costs so critical to the support of participants with developmental disabilities which are not necessarily needed for the State Plan population groups. New services such as Companion Care and Host Home are lower cost services and will expand living options. Fiscal effort will be drawn from the local dollars previously supporting potentially waiver eligible service elements.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The District Medicaid Management Information System is operated by a CMS approved external Fiscal Intermediary (FI). This FI is responsible for the operation of the MMIS system and the claims payment system that uses HIPAA compliant codes. The company providing these FI services is entitled Affiliated Computer Services (ACS). ACS has a District-based Office designed to allow staff to work directly with MAA to address any concerns on a daily basis regarding claims as well as claims details. Billing is paid out every two weeks for routine fee-for-service provider claims that are on a regular payment schedule for electronic claims. Payment is slightly longer for paper check claims and mailings, and is on a case by case basis for special claims. ACS normally processes all claims associated with the DDS waiver every two weeks. ACS also employs a Community Representative to work with MAA and DDS to address DDS waiver provider and billing issues and offer training to address payment questions and provide detailed information. MAA and DDS staff receive training on how to best use the MMIS system to review claims.

c. Certifying Public Expenditures *(select one)*:

X	**Yes**. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (*check each that applies*):	
	X	**Certified Public Expenditures (CPE) of State Public Agencies**. Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)
		DDS pays for Environmental and Vehicle Modifications in full with local dollars. Upon verification that the work is completed and the bill submitted, DDS will submit a waiver claim to the MMIS for the federal match only. DDS maintains records of bids and completed purchase orders. Related rules can be found in the DDS Payment and Invoice Certification Policy, MRDDA 14.9, effective January 11, 2007.
	☐	**Certified Public Expenditures (CPE) of Non-State Public Agencies**. Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)
O	**No**. Public agencies do not certify expenditures for waiver services.	

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The CMS-approved MMIS will be used to process all claims made under the waiver. This system is currently operated by a fiscal intermediary, ACS Government Healthcare Solutions.

In order to assure that waiver services are reimbursed only when the services were required by the Plan of Care, DDS and MAA will forward key service components to the office of Information Systems of ACS (Fiscal Intermediary) which will input the covered services into the system within 10 days of receipt of the electronic Prior Authorization. MAA must forward the information to ACS, the Fiscal Intermediary, within 3 months of receipt. Prior to payment of a claim, the system will cross check the date and type of service with those specified in the Plan of Care.

Eligibility of a participant is verified monthly before each claim is paid. The Income Maintenance Administration, Bureau of Program Operations is responsible for evaluating the eligibility of each Medicaid applicant on a recurring basis, as described in the State Plan, Attachment 4.22-A. Those individuals presenting an 853 waiver code are verified as eligible on specified date.

MRDDA Policy14.5, Service Authorization Policy, effective November 1, 2007, establishes standards and procedures that govern the way Service Authorization System (SAS) identifies the appropriate funding stream for payment of services and supports as identified in the Plan of Care. Billing does not start until implementation. Services are validated through several methods: The DDS Service Authorization Unit conducts a monthly service authorization review to verify services have been initiated through

1. Calls to agencies to ascertain start of care;
2. Calls or visits to participants to validate if services were started;
3. Validation of time and attendance sheets;
4. Case managers visit notes; and
5. Supervisor RN notes.

DDS as part of the new service authorization and fiscal integrity review processes intends to review approximately fifty service claims monthly. Specific providers may be selected in any month based on data review of claims. Each month two different agencies will be selected for a random sample of participant claims made during a designated month. The billing forms must be supported with adequate documentation by the provider. Each provider must maintain records including at a minimum:

1. Date, and time for non per-diem based services of the provision of service;
2. Prior Authorization form; and
3. Participant identification information (Name, ID Number, Sex, Date of Birth).

The documentation maintained by MAA should include at a minimum:

1. A copy of the Plan of Care (POC);
2. The date of service and length of time of each service provided to the participant, as recorded by the provider, at least including Relevant Financial Records; and
3. Notice of Eligibility Determination.

Documentation that must be forwarded to the fiscal intermediary:

1. Summary sheet from POC designating exact services the participant is eligible for, and

frequency and duration prescribed for the services;
2. Listing of approved providers with provider numbers;
3. Billing forms with information as described above; and
4. Additional information required to process claims, such as financial eligibility status (this will be handled through the Income Maintenance Administration).

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

APPENDIX I-3: Payment

a. Method of payments — MMIS *(select one)*:

X	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
O	Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
O	Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
O	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

X	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
☐	The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐	Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity. Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

X	**No**. The State does not make supplemental or enhanced payments for waiver services.
O	**Yes**. The State makes supplemental or enhanced payments for waiver services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

d. **Payments to Public Providers.** *Specify whether public providers receive payment for the provision of waiver services.*

O	**Yes.** Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. *Complete item I-3-e.*
X	**No**. Public providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

e. **Amount of Payment to Public Providers**. Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one*:

O	The amount paid to public providers is the same as the amount paid to private providers of the same service.
O	The amount paid to public providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

O	The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

X	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
O	Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
O	Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment. Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

X	**Yes**. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e). Specify the governmental agency (or agencies) to which reassignment may be made.
O	**No**. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

O	**Yes**. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10. Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:
O	**No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

O	The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.
O	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain *waiver* and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
X	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

APPENDIX I-4: Non-Federal Matching Funds

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Check each that applies:*

X	**Appropriation of State Tax Revenues to the State Medicaid agency**
X	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:
	DDS uses general funds as the source of the non-federal share after the first $2.9 million of non-federal match has been expended by MAA. This applies to all waiver services. DDS pays for Environmental and Vehicle Modifications in full. Funds are transferred through an Index process that points the payment system to DDS after the first $2.9 million has been posted as the non-federal match.
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2- c:

b. Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Check each that applies:*

☐	**Appropriation of Local Revenues.** Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
☐	**Other non-State Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
X	**Not Applicable**. There are no non-State level sources of funds for the non-federal share.

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) provider taxes or fees; (b) provider donations; and/or, (c) federal funds (other than FFP). *Select one:*

X	None of the specified sources of funds contribute to the non-federal share of computable waiver costs.	
O	The following source (s) are used. *Check each that applies.*	
	☐	Provider taxes or fees
	☐	Provider donations
	☐	Federal funds (other than FFP)
	For each source of funds indicated above, describe the source of the funds in detail:	

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

O	No services under this waiver are furnished in residential settings other than the private residence of the individual. (*Do not complete Item I-5-b*).
X	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. (*Complete Item I-5-b*)

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Waiver rates are set in advance using a cost model approach. Rates do not include any form of room and board for out of home group residential settings using the Res Hab waiver service, Host Home settings or supervised apartments using Supported Living waiver service. Room and board payments are made through a Human Care Agreement paid for using local dollars by DDS. Center-based Respite does include a room and board factor. The factor in the rates is based on the average annual occupancy expenses paid by DDS for supervised apartments and group homes in FFY 2007.

APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

X	**Yes**. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. *The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:*
	The participant will supply the lease or ownership papers for the home verifying that the participant is the lessee or the owner of the house, and an agreement between the participant and the live-in caregiver outlining the expectation and elements of waiver services to be provided. The rent will be based on the cost of the residence and apportioned to the living space for the caregiver. In most cases this will be an equal split among the residents of the home. Food will be based on USDA rates for annual food costs for District residents. The sponsoring provider agency will submit claims on behalf of the participant to DDS for payment, and transfer the funds to the participant for the specified household costs.
O	**No.** The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

X	**No**. The State does not impose a co-payment or similar charge upon participants for waiver services. (*Do not complete the remaining items; proceed to Item I-7-b*).
O	**Yes**. The State imposes a co-payment or similar charge upon participants for one or more waiver services. (*Complete the remaining items*)

i. Co-Pay Arrangement Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

	Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*
☐	Nominal deductible
☐	Coinsurance
☐	Co-Payment
☐	Other charge *(specify)*:

ii Participants Subject to Co-pay Charges for Waiver Services. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Amount of Charge	Basis of the Charge

iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

O	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
O	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. The State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one:*

X	**No**. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
O	**Yes**. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care *(specify)*:							
Col. 1	**Col. 2**	**Col. 3**	**Col. 4**	**Col. 5**	**Col. 6**	**Col. 7**	**Col. 8**
Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference (Column 7 less Column 4)**
1							
2							
3							
4							
5							

Appendix J-2 - Derivation of Estimates

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
Year 1			
Year 2			
Year 3			
Year 4 (renewal only)			
Year 5 (renewal only)			

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-d.

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

ii. Factor D′ Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

iv. Factor G′ Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

O	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
O	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year

Waiver Year: Year 1					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE WAIVER					

Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE WAIVER					

Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE WAIVER					

Waiver Year: Year 4 *(renewal only)*					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE WAIVER					

Waiver Year: Year 5 *(renewal only)*					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE WAIVER					

ii. Estimate of Factor D – Concurrent §1915(b)/§1915(c) Waivers. Complete the following table for each waiver year.

Waiver Year: Year 1						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
	☐					
	☐					
	☐					
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 2						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 3						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 4 (Renewal Only)						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 5 (Renewal Only)						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care *(specify)*:							
Col. 1	**Col. 2**	**Col. 3**	**Col. 4**	**Col. 5**	**Col. 6**	**Col. 7**	**Col. 8**
Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference (Column 7 less Column 4)**
1	$44, 714			$102, 276			
2	$55, 283						
3	$58, 287						
4	$60, 875						
5	$63, 623						

MAA, what inflator to use for the ICF/MR costs per year? Factor G

Appendix J-2 - Derivation of Estimates

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
Year 1	1455		
Year 2	1555		
Year 3	1655		
Year 4 (renewal only)	1755		
Year 5 (renewal only)	1855		

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-d.

Data derived from CMS-372(S) for waiver number 0307.09 , reporting period 11/20/04 to 10/19/05, initial report. ALOS = 272.32 days or 75%.

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

YEAR 1:

1) In-home support from FY 06 claims data for participants not residing in Supervised Apt settings, Group Homes or Community Residential Facilities. Includes all claims for attendant care, Independent Habilitation, companion, chore, personal care and homemaker. Assumes same average number of units will be utilized.
2) Supported Living based on average costs per person from FY 06 waiver claims data and Human Care Agreements local costs data. Includes all res support services and nursing costs.
3) Res Hab based on average costs per person from FY 06 waiver claims data and Human Care Agreements costs data. Includes all res support services and nursing costs.
4) Services that align with current waiver are based on FY 06 claims data.
5) PT, OT, SPL and Nutrition add utilization from Human Care Agreements in addition to FY 06 waiver claims data.
6) Live in companion/caregiver and Host Home. Professional estimate of number of participants who would choose these support arrangements.
7) Behavior Supports and Community Support Team based on claims utilization in FY 06 for Crisis Preventions services under current waiver. Behavior adds utilization data from Human Care Agreements for psychological services.

8) Home and Vehicle modifications, professional judgment regarding increased access to these services.
9) One time Transitional services. Estimate of number of participants who may choose to establish an independent living arrangement.
10) Professional Services, based on an estimate of participants who may choose to access these support options.
11) Transportation based on average costs per person from FY 06 waiver claims data. Assumes 75% to be used for transportation for vocational support and 25% for community access.

Year 2: Year 2 projects higher utilization for most services as the year 1 enrollees experience a full year of service. The additional 100 participants will be the result of converting 100 participants to the HCBS waiver from community ICF/MR settings. Specific details follow.

1) In-home supports: decrease by 25 participants who move to out of home settings. Increase utilization to 20 hours per week of support.
2) Supported Living rates will be based on acuity of participants needs. Project 100 participants will remain in 1:1 services, and the remaining 282 participants will on average split evenly between 2 person and 3 person settings.
3) Res Hab rates will be developed to reflect intensity of service needs. Project 1/3 of existing year 1 participants plus 100 participants transitioning from ICF/MR will require intensive supports, and the remaining 2/3 of the year 1 participants will require basic res hab level services.
4) Day Hab, add an additional 60 participants from the 100 participants transferring from ICF/MR. Increase utilization to a full year of anticipated service levels, 212 days for approximately 5 hours per day.
5) Pre-vocational, add 20 participants from the ICF/MR group, and increase utilization to full service levels as above.
6) SE Placement, increase participants by 10 for general growth in service interest.
7) SE follow-along services, increase participants by 10 and increase utilization to 22.4 hours per week.
8) Group SE services, increase participants by 10 and utilization as above.
9) Group and hourly Respite, increase participants to 1/3 of participants receiving in-home supports. Hourly respite increase utilization to 80% of allowable service amount.
10) Live-in companion, increase growth by 10 participants and room and board costs by 2%.
11) Dental increase participants by 100 for participants transitioning from ICF/MR. Raise rate by 4.2% for MCPI.
12) PT, OT, SPL, Nutrition and Behavior Supports, add 50 participants each from those transitioning from ICF/MR.
13) Skilled Nursing increase utilization to 10 visits per year.
14) Community Support Team add 10 participants (10% of new).
15) Host Home add 15 participants a year as interest and provider base grows. Movement from in-home supports.
16) PERS, add 9 each year per historical utilization.
17) Professional services, double participants based on increased awareness of service options and increased available providers of service in year 2.
18) Transportation increase for vocational by 90 participants to account for ICF/MR participants transferring to HCBS waiver. Community access transportation remains the

same.

Year 3: All Rates increase by 2%, except professional services, acupuncture and dental which rise 4.2% to align with MCPI.

1) In-home reduce by 25 as individuals gain out of home supports.
2) SL remains the same number of participants.
3) Res Hab, increase by 75 to intensive levels and 25 people to basic levels to account for 100 additional participants transferring from ICF/?MR settings.
4) Professional service participants increase by 1/3 over year 2.
5) Acupuncture service participants increase by 1/3.

Year 4 and Year 5.

Same assumptions as year 3.

ii. Factor D′ Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Based on FY 06 claims for DDS waiver participants less prescription drug costs for participants who were dual eligibles. (need this from MAA, dual eligible prescription figure to deduct?)

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is derived from the FFY 06 ICF/MR claims data.

iv. Factor G′ Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

CMS-372(S)for the Reporting period 11/20/04 –11/19/05, inflated using the MCPI. Prescription drug costs for dual eligibles have been removed by determining average paid claims for those participants in the reporting period 11/04 to 11/05, and determining the percentage of dual eligible participants in the target group. (MAA is this one way of getting to this number? PGS does not have data to calculate at this time)

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

●	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
O	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year

Waiver Year: Year 1

Waiver Service	Column 1 Unit	Column 2 # Users	Column 3 Avg. Units Per User	Column 4 Avg. Cost/ Unit	Column 5 Total Cost
In-home Support	1 hour	509	552	$ 20.00	$ 5,619,360.00
Supported Living	day	382	274	$ 227.00	$ 23,759,636.00
Res Hab	day	318	274	$ 220.00	$ 19,169,040.00
Day Hab	1 hour	465	844	$ 14.11	$ 2,585,093.00
Pre-Voc	1 hour	407	515	$ 14.11	$ 1,401,235.00
SE Placement	1 hour	29	207	$ 40.62	$ 243,842.00
Supported Employment	1 hour	291	267	$ 22.97	$ 1,784,700.00
Group SE	1 hour	73	267	$ 16.80	$ 327,448.80
Center Based Respite	1 day	146	17	$ 276.00	$ 685,032.00
Respite	1 hour	146	338	$ 18.25	$ 900,601.00
LI Companion	1 day	29	274	$ 23.00	$ 182,758.00
Caregiver-rm&bd	1 day	29	274	$ 29.69	$ 235,916.00
Dental	1 unit	291	1	$ 179.00	$ 52,089.00
OT	1hour	131	13	$ 65.00	$ 110,695.00
PT	1 hour	73	8	$ 65.00	$ 68,120.00
SPL	1 hour	351	21	$ 65.00	$ 479,115.00
Skilled Nursing	1 hour	44	25	$ 65.00	$ 94,380.00
Behavior Supports	1 hour	349	12	$ 34.00	$ 142,392.00
Community Support Team	1 unit	116	5	$ 240.00	$ 139,200.00
Environmental Modifications	1 unit	58	1	$ 5,000.00	$ 290,000.00
Vehicle Modifications	1 unit	29	1	$ 5,000.00	$ 145,000.00
Host Home	I day	29	267	$ 72.00	$ 557,496.00
Nutrition	1 hour	495	10	$ 55.00	$ 272,250.00
family training	1 hour	58	4	$ 50.00	$ 11,600.00
One-time Transitional	1 unit	58	0.75		$ 217,500.00
PERS	1 month	15	9	$ 28.50	$ 3,847.50
PERS installation	1 unit	9	1	$ 40.00	$ 360.00
Professional Services	1 hour	45	9	$ 80.00	$ 32,400.00
Acupuncture	1 hour	15	2	$ 70.00	$ 2,100.00
Transportation -Comm	1 unit	1062	0.75	$ 1,741.00	$ 1,386,707.00
Transportation-Voc	1 unit	1062	0.75	$ 5,222.00	$ 4,159,323.00
Grand Total					$ 65,059,236.30
# Unduplicated (Factor C)		1455			
Factor D (per capita average) C					$ 44,714.25

Waiver Year: Year 3

Waiver Service	Column 1 Unit	Column 2 # of Users	Column 3 Avg. Units User	Column 4 Avg. Cost/ Unit	Col. 5 Total Cost
In-home Support	1 hour	459	780	$ 20.40	$ 7,303,608.00
Supported Living:1	day	100	274	$ 436.56	$ 11,961,744.00
Supported Living:2	day	141	274	$ 241.74	$ 9,339,383.16
Supported Living:3	day	141	274	$ 176.46	$ 6,817,355.64
Res Hab	day	305	274	$ 168.30	$ 14,064,831.00
Res Hab: Intensive	day	213	274	$ 273.36	$ 15,953,836.32
Day Hab	1 hour	585	795	$ 14.39	$ 6,693,452.42
Pre-Voc	1 hour	447	795	$ 14.39	$ 5,114,484.15
SE Placement	1 hour	49	207	$ 41.43	$ 420,248.83
Supported Employment	1 hour	311	660	$ 23.43	$ 4,809,118.64
Group SE	1 hour	93	660	$ 17.14	$ 1,051,807.68
Center Based Respite	1 day	160	17	$ 281.52	$ 765,734.40
Respite	1 hour	160	432	$ 18.62	$ 1,286,668.80
LI Companion	1 day	49	274	$ 23.46	$ 314,973.96
Caregiver-rm&bd	1 day	49	274	$ 30.89	$ 414,670.07
Dental	1 unit	491	1	$ 259.08	$ 127,208.28
OT	1hour	231	13	$ 66.30	$ 199,098.90
PT	1 hour	173	8	$ 66.30	$ 91,759.20
SPL	1 hour	451	21	$ 66.30	$ 627,927.30
Skilled Nursing	1 hour	44	30	$ 66.30	$ 87,516.00
Behavior Supports	1 hour	424	12	$ 34.68	$ 176,451.84
Community Support Team	1 unit	136	5	$ 244.80	$ 166,464.00
Environmental Modifications	1 unit	58	1	$ 5,000.00	$ 290,000.00
Vehicle Modifications	1 unit	29	1	$ 5,000.00	$ 145,000.00
Host Home	I day	59	267	$ 73.44	$ 1,156,900.32
Nutrition	1 hour	599	10	$ 56.10	$ 336,039.00
family training	1 hour	58	4	$ 51.00	$ 11,832.00
One-time Transitional	1	30	0.75	$ -	$ 217,500.00
PERS	1 month	33	9	$ 29.07	$ 8,633.79
PERS installation	1 unit	9	1	$ 40.80	$ 367.20
Professional Services	1 hour	120	9	$ 83.36	$ 90,028.80
Acupuncture	1 hour	27	2	$ 72.94	$ 3,938.76
Transportation -Comm	1 unit	1062	0.75	$ 1,775.82	$ 1,414,440.63
Transportation-Voc	1 unit	1252	0.75	$ 5,326.44	$ 5,001,527.16
Total Column E.					$ 96,464,550.25
# Unduplicated (Factor C)	1655				
Factor D (per capita average) C					$ 58,286.74

Waiver Year: Year 4

Waiver Service	Column 1 Unit	Column 2 # of Users	Column 3 Avg. Units Per User	Column 4 Avg. Cost/ Unit	Column 5 Total Cost
In-home Support	1 hour	434	780	$ 20.81	$ 7,043,924.16
Supported Living:1	day	100	274	$ 445.29	$ 12,200,978.88
Supported Living:2	day	141	274	$ 246.57	$ 9,526,170.82
Supported Living:3	day	141	274	$ 179.99	$ 6,953,702.75
Res Hab	day	330	274	$ 171.67	$ 15,522,039.72
Res Hab: Intensive	day	288	274	$ 278.83	$ 22,002,812.01
Day Hab	1 hour	645	795	$ 14.68	$ 7,527,559.56
Pre-Voc	1 hour	467	795	$ 14.68	$ 5,450,186.54
SE Placement	1 hour	59	207	$ 42.26	$ 516,134.18
Supported Employment	1 hour	321	660	$ 23.90	$ 5,063,027.74
Group SE	1 hour	103	660	$ 17.48	$ 1,188,203.39
Center Based Respite	1 day	160	17	$ 287.15	$ 781,049.09
Respite	1 hour	160	432	$ 18.99	$ 1,312,402.18
LI Companion	1 day	59	274	$ 23.93	$ 386,839.45
Caregiver-rm&bd	1 day	59	274	$ 31.50	$ 509,282.54
Dental	1 unit	591	1	$ 264.26	$ 156,178.61
OT	1hour	281	13	$ 67.63	$ 247,037.78
PT	1 hour	198	8	$ 67.63	$ 107,119.58
SPL	1 hour	501	21	$ 67.63	$ 711,493.15
Skilled Nursing	1 hour	44	30	$ 67.63	$ 89,266.32
Behavior Supports	1 hour	474	12	$ 35.37	$ 201,205.04
Community Support Team	1 unit	146	5	$ 249.70	$ 182,278.08
Environmental Modifications	1 unit	58	1	$ 5,000.00	$ 290,000.00
Vehicle Modifications	1 unit	29	1	$ 5,000.00	$ 145,000.00
Host Home	I day	74	267	$ 74.91	$ 1,480,048.07
Nutrition	1 hour	649	10	$ 57.22	$ 371,370.78
family training	1 hour	58	4	$ 52.02	$ 12,068.64
One-time Transitional	1	30	0.75	$ -	$ 217,500.00
PERS	1 month	42	9	$ 29.65	$ 11,208.23
PERS installation	1 unit	9	1	$ 41.62	$ 374.54
Professional Services	1 hour	160	9	$ 83.36	$ 120,038.40
Acupuncture	1 hour	35	2	$ 72.94	$ 5,105.80
Transportation -Comm	1 unit	1062	0.75	$ 1,811.34	$ 1,442,729.44
Transportation-Voc	1 unit	1242	0.75	$ 5,432.97	$ 5,060,810.44
Total Column E.					$106,835,145.89
# Unduplicated (Factor C)	1755				
Factor D (per capita average)/C					$ 60,874.73

Waiver Year: Year 5

Waiver Service	Column 1 Unit	Column 2 # Users	Column 3 Avg. Units Per User	Column 4 Avg. Cost Unit	Column 5 Total Cost
In-home Support	1 hour day	409	780	$ 21.22	$ 6,770,931.52
Supported Living:1	day	100	274	$ 454.20	$ 12,444,998.46
Supported Living:2	day	141	274	$ 251.51	$ 9,716,694.24
Supported Living:3	day	141	274	$ 183.59	$ 7,092,776.81
Res Hab	day	355	274	$ 175.10	$ 17,031,910.86
Res Hab: Intensive	1 hour	363	274	$ 284.40	$ 28,287,365.19
Day Hab	1 hour	705	795	$ 14.97	$ 8,392,353.61
Pre-Voc	1 hour	487	795	$ 14.97	$ 5,797,271.22
SE Placement	1 hour	69	207	$ 43.11	$ 615,686.84
Supported Employment	1 hour	331	660	$ 24.38	$ 5,325,169.55
Group SE	1 day	113	660	$ 17.83	$ 1,329,634.20
Center Based Respite	1 hour	160	17	$ 292.89	$ 796,670.07
Respite	1 day	160	432	$ 19.37	$ 1,338,650.22
LI Companion	1 day	69	274	$ 24.41	$ 461,453.56
Caregiver-rm&bd	1 unit	69	274	$ 32.13	$ 607,513.65
Dental	1hour	691	1	$ 269.55	$ 186,256.86
OT	1 hour	331	13	$ 68.98	$ 296,814.57
PT	1 hour	248	8	$ 68.98	$ 136,853.38
SPL	1 hour	551	21	$ 68.98	$ 798,150.45
Skilled Nursing	1 hour	44	30	$ 68.98	$ 91,051.65
Behavior Supports	1 unit	524	12	$ 36.08	$ 226,877.78
Community Support Team	1 unit	156	5	$ 254.69	$ 198,658.14
Environmental Modifications	1 unit	58	1	$ 5,000.00	$ 290,000.00
Vehicle Modifications	I day	29	1	$ 5,000.00	$ 145,000.00
Host Home	1 hour	89	267	$ 76.41	$ 1,815,658.97
Nutrition	1 hour	699	10	$ 58.37	$ 407,981.42
family training	1	58	4	$ 53.06	$ 12,310.01
One-time Transitional	1 month	30	0.75	$ -	$ 217,500.00
PERS	1 unit	51	9	$ 30.24	$ 13,882.19
PERS installation	1 hour	9	1	$ 42.45	$ 382.03
Professional Services	1 hour	213	9	$ 83.36	$ 159,801.12
Acupuncture	1 unit	47	2	$ 72.94	$ 6,856.36
Transportation -Comm	1 unit	1062	0.75	$ 1,847.56	$ 1,471,584.03
Transportation-Voc		1332	0.75	$ 5,541.63	$ 5,536,086.55
Total Column E.					$ 118,020,785.51
# Unduplicated (Factor C)		1855			
Factor D (per capita average) C					$ 63,623.06

ii. Estimate of Factor D – Concurrent §1915(b)/§1915(c) Waivers. Complete the following table for each waiver year.

Waiver Year: Year 1						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 2						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 3						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 4 (Renewal Only)						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 5 (Renewal Only)						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						